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Worldwide Report

EPIDEMIOLOGY

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HUMAN DISEASES

ANIMAL DISEASES

25-POINT ACTION PLAN ADOPTED AT CARIBBEAN HEALTH MEETINC

Kingston THE DAILY GLEANER in English 7 Apr 82 p 7

[Text] Ministers of Health in the Commonwealth Caribbean countries meeting in St. Kitts/Nevis on January 25 and 26 to exchange views on the policy issues underlying "Primary Health Care Approach" adopted a 25-point plan of action included in a document of the June 1981 workshop in Saint Lucia.

A release from the CARICOM Secretariat said the principal document that the consultation had before it was the Strategy and Plan of Action that had been produced by Caribbean health officials at a workshop in St. Lucia in June last year.

They adopted the 25-point plan of action included in the strategy, and considered it worthy of careful study not only in the health sector, but also by officials in the other sectors, that contribute to the health of the people.

The meeting decided that its goal could only be met if there was simultaneous action in every country, in three main areas. These included the integration of health and development planning and the establishment of effective mechanisms of co-operation with the other sectors that contribute to health such as Central Planning, Agriculture, Education, Housing, Public Works, Labour, Community Development and Communications.

In addition, there had to be the involvement of the mass of the people in every health activity, including promotion, planning, implementation, evaluation and intensification of Health Education. Finally, there was the re-orientation and re-structuring of health services incorporating more dynamic management and a progressive shift of resources in the direction of primary health care.

PEOPLE'S ROLE

The need to establish an effective mechanism for achieving inter-sectoral co-ordination at various levels, such as the establishment of National Health Councils at the central level, and the organisation of effective community committees at local level, was also recognised. Where community participation was concerned, the Ministers saw the need to intensify effective health education efforts so that people could play a more responsible role in maintaining and conserving their own health.

The consultation adopted the basic philosophy that all community workers must primarily be educators, and that all technical activities must have an educational component. Every health facility should serve as a classroom and a regional mechanism was necessary to develop appropriate educational materials.

If each country were to achieve primary health care, the re-distribution of financial resources was vital, and this would require firm political will. The Ministers stressed the need for a comprehensive review of the system of financing of the health services in the Caribbean community to increase these resources.

CSO: 5400/7549

BATTLE AGAINST DEADLY GOLDEN STAPH VIRUS CONTINUES

Canberra THE AUSTRALIAN in English 31 Mar 82 p 3

[Article by Sue Cook]

[Text]

HOSPITALS in Victoria are fighting a desperate battle to contain a deadly and possibly unique form of golden staphylococcus infection which has been linked with more than 100 deaths in the State.

The deputy director of public health at the Victorian Health Commission, Dr Graham Rouche, said yesterday the bacteria appeared to be a stronger, more aggressive strain than that found in hospitals elsewhere in this country and overseas.

"It gets out of hand much more quickly than similar strains," he said. "There is a slight variant within the strain and it has some extra survival mechanism."

There is also increasing concern that the last line of defence against the bug is in danger of becoming ineffective.

The Victorian strain is resistant to all but one antibiotic, which can cause deafness and other damage to patients whose kidney functions are already impaired.

Golden staph can cause serious abcesses and ulcers. It is a particular problem for patients with lowered resistance to disease, often causing blood poisoning or septicaemia in these cases.

A report of the extent of the infection in Victorian hospitals, published in the Health Department's Communicable Diseases Intelligence Bulletin, shows that each month since November 1980 there have been more than 300 notifications of the strain.

The bulletin also says the infection can be spread by airborne bacteria and through skin contamination, even when strict cleanliness standards are applied.

BURDEN

Research being conducted at Melbourne's Monash University on the bacteria, known as methicillin-resistant staphylococcus aureus, has shown that it might be a genetic variant.

Dr Rouche said the bacteria had many sub-strains, the only common feature being a resistance to drugs.

There were no imminent breakthroughs in antibiotic treatment.

"It is not necessarily more virulent, it is more its capacity to infect and jump the barrier."

Patients contracting the infection while in hospital often had to wait a very long time before they could be discharged, thus placing a great burden on the expensive facilities of teaching hospitals.

CSO: 5400/7550

BRIEFS

ROSS RIVER, DENGUE FEVER--Brisbane--Queensland was in the grip of Ross River fever and Dengue-fever epidemics, the State's Health Minister, Mr Austin, warned yesterday. Cases of Ross River fever were occurring in south-east Queensland and Dengue fever was a problem as far south as Gladstone, he said. There was a possibility that both viral diseases, transmitted by mosquitoes, could spread across the NSW border. The diseases were not dangerous and there was no known cure for the Ross River fever, but sufferers could be afflicted for up to a year. Ross River fever is characterised by fever, malaise, headache, sore and swollen joints and sometimes a rash. Dengue fever has similar symptoms. There had been about 160 cases of Ross River fever identified so far this year, compared with 400 last year, Mr Austin said. Most cases this year had been reported in south Queensland, including Goondiwindi, Roma, Toowoomba and Brisbane. There had been 47 cases of Dengue fever so far this year, mainly on Thursday Island. Mr Austin appealed to the public to empty all fresh-water containers. Mosquito eradication programmes throughout the State were not working, he said. The response from some local authorities to combat the two fevers had been disappointing. "Unless a more concerted effort is made, a more widespread outbreak could occur," he said. [Text] [Perth THE WEST AUSTRALIAN in English 7 Apr 82 p 34]

CSO: 5400/7551

EPIDEMICS, HEALTH PROBLEMS BLAMED ON BACTERIOLOGICAL WARFARE

Countermeasures Noted

Havana TRABAJADORES in Spanish 29 Mar 82 p 2

[Article by Silvia Martinez]

[Text] Biological warfare is one of imperialism's underhanded and criminal ways of causing death and destruction. Lately, Cuba has had agonizing ex eriences: sugar cane rust, tobacco blue mold, and hog cholera, mysteriously introduced into our country for the purpose of ruining our economy.

Aside from hemorrhagic conjunctivitis, the most painful aggression was hemorrhagic dengue epidemic that cost a hundred lives.

The people still recall the days when health workers and mass organizations and the State undertook to get rid of the virus and its vector, the Aedes aegypti mosquito.

All types of medical attention possible were put in action, guard units and hospital rooms were staffed to full capacity, mainly by pediatricians, and our commander in chief came up with the idea of creating intensive care units in all childrens' hospitals.

Imperialism attacked our people with its wrath and impotence and struck at the most sensitive point, mankind; children the concern and dream of our socialist society. But our revolutionary conscience was more powerful and with immense effort, in a few months we made the epidemic vanish, an unprecedented event in the world.

Moreover, since 10 October, when the virus was detected and an intensive phase of the campaign was begun, to the present time, the rate of mosquito infection has been reduced to .013 percent.

Nearly 45 million pesos were spent to eradicate the disease and the vector mosquito, and more than 13,000 men and women learned the technique quickly for vector control, not counting increases in hospital personnel, workers who, aware of the situation, doubled their work hours in order to attend to or admit any patient with suspicious symptoms.

The fight against transmissible diseases should not be a task for a single day, but a permanent one for all the people in the defense of their health. One of the preventive measures for controlling any type of epidemic is hygiene and environmental cleanliness, because, although every measure has its own characteristics, with this one there is a greater guarantee against the breeding of certain types of carriers.

For example, a work center where foods are cooked and products are not well stowed in the warehouse or where leftovers are thrown out indiscriminately is a sure source of nutrition for rodent carriers of leptospirosis and other no less harmful diseases.

During April and May the seasonal rains arrive and with them come the logical danger of mosquito breeding, of which Aedes aegypti is the greatest. Do not lose sight of the fact that one infected specimen of this small, but dangerous, enemy is sufficient to start an epidemic with grave consequences.

The risk is avoided only by strict compliance with all the measures recommended by Public Health designed to eliminate potential breeding places which can even be an insignificant eggshell.

This matter should go hand in hand with greater precision and quality in technical work done by vector controllers and supervisors, as well as that of all health service directors in different situations and, in addition, active participation of unions with work center administrators for complying with Law Decree 27, which is fundamental.

All preventive measures taken to avoid transmissible diseases turn out to be insufficient and efforts made are few. It is indispensable to keep trying because man's health is what is basic to all else.

U.S. Blamed

Havana TRABAJADORES in Spanish 29 Mar 82 p 2

[Article by Igor Blishchenko]

[Text] The problem of using chemical weapons in Southeast Asia and in Afghanistan has been the object lately of wide speculation in the Western press.

U.S. officials blame this serious war crime on the Soviet Union. They blame the USSR superficially without citing a single act or concrete proof. Even a group of experts from the UN, formed at the insistence of the United States, who investigated "intelligence reports" on the use of chemical warfare, recognized that those experts had been unable to discover traces or signs that would confirm them.

No other conclusion could be reached, if "proofs" presented by the United States were taken as a basis.

Now, let's see whether or not the United States has the right to cast doubt on the Soviet Union's fulfilling its international obligations which prohibit the use of chemical warfare.

Let's remember that the USSR in 1928 was one of the first states to ratify the Geneva Convention of 1925 which forbade use of bacteriological and chemical warfare. The United States complied with it only after 50 years in 1975. Before that, as is known, it used widely harmful substances in Vietnam. Traces of chemical warfare have remained not only in Vietnam. The traces lead to the U.S., New Zealand, Australia and South Korea whose soldiers fought in Southeast Asia and suffer the consequences of chemical warfare that made them invalids.

In the 1950s the Soviet representative to the UN Security Council proposed to call on the states which had not ratified the Convention to do so. The United States abstained this time, too. In 1963, during the 24th session of the UN General Assembly, the USSR and other socialist countries presented a proposal convention that would prohibit the invention, production, and use of chemical and bacteriological (biological) weapons. At that time several capitalist countries refused to look into the problems relating to chemical weapons, arguing that it was difficult to keep track of them. Despite it all, the Soviet Union insistently kept searching for a way to achieve total prohibition of the "silent weapon." In 1971, at the initiative of the USSR at the Committee on Disarmament, a proposed resolution was presented that stipulated the prohibition of invention, production, and accumulation of bacteriological (biological) and toxic weapons which should be done away with. On 10 April 1972 in Moscow, Washington and London the special convention was signed.

In 1975, the USSR, the United States and Great Britain in the Committee on Disarmament stated they no longer had any reserves in bacteriological weapons. Nevertheless, in March 1980 at the international conference where the effect of the Geneva Convention was analyzed, an attempt was made to blame the USSR of violating certain clauses in it. The USSR officially confirmed that it does not have any bacteriological (biological) agents of any kind, that it possesses no toxins, weapons, equipment or transportation means mentioned in Article I of the Convention. Since then in spite of these facts and the logical conclusions, without taking into consideration the opinion of respected persons or specialists--North Americans, among others--certain U.S. politicians frightened the world with a new, provocative campaign.

Meanwhile--what follows is not widely known in the United States--since 1980 the United States had interrupted the Soviet-North American talks on prohibiting chemical warfare, despite the fact that they had reached important agreements.

Meanwhile, talks started in 1976 were progressing, the United States revived the program for increasing the manufacture of its chemical weapons. During the Carter administration a 4-year program for preparing for this kind of warfare was put into effect, for which 2.47 billion dollars was set aside. Now the amount appropriated for that purpose has already reached 4 billion. Factories are being built that produce binary projectiles. Despite the declaration made in 1975, the United States has airborne containers with bubonic plague, Siberian ulcer and encephalitis agents. The supplies of paralyzing gas number thousands of tons.

And these weapons are not deadweight. Noxious chemical substances produced in the United States--grenades and poisons--are employed by Afghan counterrevolutionaries against civilian populations, even against school children.

With this background, it is fair to say that the United States, through Secretary of State A. Haig, has no right to accuse the USSR of using chemical weapons. The USSR has never done so, our affirmation is supported by the First Committee of the UN General Assembly of which decidedly rejected such provocation. Taking into consideration the desire of the North American administration to turn attention away from its preparation for chemical warfare outside its own borders, it is necessary to adopt serious and responsible measures to achieve a consistent and universal prohibition of the use of chemical warfare.

9908
CSO: 5400/2149

MINISTRY OF PUBLIC HEALTH ANTIMALARIA CAMPAIGN SET

Havana GRANMA in Spanish 17 Apr 82 p 3

[Article by Jose A. de la Osa]

[Text] As part of a series of steps being taken by the Ministry of Public Health [MINSAP] to intensify epidemiological vigilance of diseases which do not exist in Cuba, a controlled antimalaria treatment campaign will be waged, beginning next Monday and continuing through the 25th, sponsored by the Committees for the Defense of the Revolution [CDR] and MINSAP, directed at the internationalists who have returned to Cuba between 1 January 1981 to the present.

The purpose of the campaign is to reduce the potential reservoir of disease created by people coming from countries where there is malaria and who have not undergone the complete antimalaria treatment.

The disease, referred to as either paludism or malaria, is caused by a parasite carried by the anopheles mosquito which has no domestic habits, and which therefore, is almost impossible to eradicate.

The preference of the anopheles mosquito for particular types of depositories for breeding varies a great deal according to the species and foci of this vector can be found in natural or artificial receptacles, which contain clean water or water with varying degrees of organic material, in shade or sun, with vegetation or without it.

The national vigilance system for Cuban international travelers requires that all travelers from areas endemic with malaria, upon arriving in Cuba, must receive an epidemiological medical examination, laboratory tests and the administration of treatment for the disease.

According to information given to GRANMA by Doctor Enrique Galban Garcia, an epidemologist for MINSAP in charge of international health control, a study carried out in recent years indicated that a significant percentage of travelers have not attended the initial examination at the Institute of Tropical Medicine and of those who do attend, a certain number do not complete the radical treatment prescribed for them.

As a solution to this problem, at the direction of our revolutionary government, examination and treatment centers are being established in the main countries served by our internationalists which will have as their principal function the examination of all travelers at the end of their mission in the same country where they work and the administration of a controlled, radical antimalaria treatment.

"These measures," stated Dr Galban, "will allow better control of travelers exposed to malaria and a reduction of the risk of reintroducing the disease into our environment."

Malaria is the most common communicable disease known to mankind and 200 million people in the world are currently suffering from it, mainly in the so-called Third World.

Because of its climatic conditions, our country offers fertile grounds for the propagation of this disease by allowing year-round reproduction of the anofeles mosquito vector.

At the time of the triumph of the Revolution, malaria was one of the leading causes of death in our country (in frequency) by communicable disease. It was eradicated in 1967, the year in which the last local case was reported.

The World Health Organization, after a period of strict observation of this disease, awarded Cuba the certificate of "Territory Free of Malaria" in 1973, and today it is displayed as one of the most important achievements attained by our people in the area of health.

Malaria is a curable disease, the symptoms of which are a fever, perspiration and chills, followed by periods which may last for months in which there are no symptoms present.

The treatment to be used in the campaign now being initiated will be a daily dose of two 15 milligram Primaquine tablets given for 5 days.

Seen as vitally important in the success of this campaign, is the participation of CDR, an organization of the masses which because of its national scope, its knowledge of the people and its experience in other health-related activities, especially the polio vaccination campaigns, is the most appropriate vehicle for obtaining basic information for this campaign, that is the census of internationalists, a task already accomplished with great success.

For these same reasons, CDR will be in charge of supervising the attendance of all those registered for treatment by the census.

In the polyclinics, a special consultation room will be provided for the administration of treatment to the travelers who have been registered by the census, and it will be open from 8 am to 9 pm.

9787
CSO: 5400/2142

BRIEFS

POLIO CAMPAIGN RESULTS SATISFACTORY--Havana--Final figures for the second stage of the 21st antipolio campaign indicate that with 690,363 children targeted for vaccination, a total of 771,699 were vaccinated, thus exceeding the goal by 11.8 percent. Specialists from the National Office of Epidemiology of the Ministry of Public Health reported to GRANMA, "The results are satisfactory in all of the provinces." They emphasized the outstanding work performed by the Committees for the Defense of the Revolution [CDR] in this labor of love. The results by province follow: Pinar del Rio, 110.4 percent; Havana, 113.0; City of Havana, 109.8; Matanzas, 111.4; Villa Clara, 110.2; Cienfuegos, 113.6; Sancti Spiritus, 112.9. Ciego de Avila, 115.4; Camaguey, 113.3; Las Tunas, 125.9; Holguin, 119.4, Granma, 113.1; Santiago de Cuba, 104.3; Guantanamo, 104.5; and the special district, Isla de la Juventud, 110.8. As we know, in this second stage those children 9 years of age received a booster. [Text] [Havana GRANMA in Spanish 22 Apr 82 p 3] 9787

CSO: 400/2142

POLIO INCIDENTS RESULT FROM LACK OF VACCINE

Santo Domingo EL NACIONAL in Spanish 28 Apr 82 p 2

[Excerpts] The director of the medical department of the Dominican Pro-Family Welfare (PROFAMILIA) stated that the lack of necessary program mechanisms for controlling poliomyelitis is why this illness continues to affect the infant population of the nation.

Dr Miguel Campillo Llibre admitted, however, that for some years authorities in the Secretariat of Public Health have been carrying out serious efforts through a group of technicians for controlling the disease.

He supported the proposal made by newsman Rafael Herrera, director of LISTIN DIARIO, that 2 days annually should be set aside for vaccinations.

Campillo added that the 2 days for nationwide vaccinations should not be for poliomyelitis alone, but that every effort should be made to give two vaccines: one against the disease itself and another to immunize children against diphtheria, tetanus and whooping cough (a triple vaccine).

In focusing on the problem of poliomyelitis, according to announcements, 57 cases have already been detected within the year, the doctor wondered: "What is happening, when a disease that is prevented by using such a simple vaccine, that administering two drops in a child's mouth, with a 4 to 6 weeks' interval, avoids this condition and vaccines only cost from 6 to 8 cents?"

"Poliomyelitis is still with us," he responded, "simply because the program mechanisms necessary for controlling epidemic outbreaks are not used."

He explained that the days proposed for a nationwide vaccination campaign by LISTIN DIARIO are not enough to control the disease totally because children born following those days, that is to say the recent susceptibles, will not be immunized.

9908
CSO: 5400/2145

MEDICAL UNION CHIEF LISTS DOMESTIC HEALTH PROBLEMS

Cairo AL-MUSAWWAR in Arabic No 2999, 2 Apr 82 pp 22-25, 79-81

[Article: "Hamdi al-Sayyid, Head of the Doctors' Union, in a Provocative Conversation with AL-MUSAWWAR"]

[Text] Dr Hamdi al-Sayyid, the head of the Doctors' Union, rebukes the press; his rebuke has taken the form of the discussion and questions he raised on essential matters related to Egypt's press. It was in the framework of this atmosphere that he came to a colloquium at AL-MUSAWWAR. This has a unique status among all the colloquia that AL-MUSAWWAR has held up to now. The rebuke exists only among people who are brought together under a common jurisdiction and it translates a desire to resume discourse and seek points of agreement among immense areas of disagreement.

Nonetheless, the rebuke of the press which the head of the Doctors' Union formulated in the shape of the questions he presented to the journalists' table, after which we went about his business, occupied a small portion of a large colloquium which started, went on, then ended. Everyone tried to answer this question: What about the health of the ill, worn down Egyptian people who have long yearned for moments of restored vigor?

The conversation with Dr Hamdi al-Sayyid, chief of the Egyptian Doctors' Union, member of the People's Assembly for the Heliopolis District, member of the National Democratic Party parliamentary committee and the well known Egyptian cardiac physician, took 4 hours in length and breadth.

We members of the AL-MUSAWWAR family who were present at this conversation can testify that the man had presence of mind and was quick witted. We agree and admit that when he came into the expansive symposium room at the al-Hilal House he was not carrying a piece of paper with him. All figures, facts and percentages were stored up and arranged in his mind and he mastered them during the conversation with a rare simplicity. His conversation did not revolve in the orbit of the health of the Egyptian people in its limited, simple-minded sense — he spoke about Egypt and its social, political and party health.

Dr Hamdi al-Sayyid spoke warmly, impusively and sincerely about the issue of sanitation in Egypt, and the fact that it is principally a matter of civilized behavior. We spoke about the Nile River, the giver of life to Egypt, whose wretchedness has now reached the state where it is no longer able to cleanse itself of all the forms of daily pollution that flow into it from its source to its mouth. He also spoke about

the endemic diseases in Egypt, medical treatment, the government's obligations on that, health insurance, the time he thought it would take for coverage to extend to all Egyptians, and what was required for that purpose. He spoke about our children in the schools, concerns of malnutrition, the cities in Egypt and pollution caused by sewers.

Since his conversation was a tour throughout all of Egypt, he spoke about Jamal 'Abd-al-Nasir, the man who created one of the most glorious of Egypt's periods, and Anwar al-Sadat, through whose efforts and accomplishments Egypt gained much of the status it has in the world today, and he wondered in whose interests it was that 'Abd-al-Nasir entered history in such a way that his era was considered one of torture and terror, and Anwar al-Sadat in such a way that the period of his rule was considered to have offered nothing but a true corruption of everything that was holy.

He said that he had decided to honor Jihan al-Sadat and that someone got in touch with him to chastize him [for that].

He said that he was sad because we had not retained a single value we could cherish. We have heaped dirt on the era of 'Abd-al-Nasir, we are now heaping dirt on the era of al-Sadat, and we have become like cats that eat their offspring. He wondered, angrily, who we could take pride in now — Ramses the First?

He said that he was not against free medical treatment but that that treatment should be for the indigent and that it should just involve preventive medicine. Concerning the treatment that is offered people in government hospitals, he said that that was now deteriorating, that most of our hospitals were built before 1935 and that nothing could be worse than the present situation.

He spoke about the hot topic — doctors' excessively high fees and the crisis in doctors' taxes. He stressed that it was an ancient tradition that some doctors tried to evade taxes, that some paid what they owed, and that doctors were not angels, but that the Tax Department's mission was to prosecute people who paid and neglect people who did not pay and whom it did not know.

When we came to medical education, he said that we were the only country where a new medical faculty was opened every year and medicine was taught in a language alien to it.

He wondered, "Why doesn't the al-Azhar Medical Faculty play a part in Arabizing medical education?"

The issue of family planning also occupied some of the space in the colloquium. He said "Suffice it for us to say that in Bab al-Sha'riyah and Rawd al-Faraj there are 105,000 people per square kilometer, which is the highest rate of population density in the world now. There are many people in Egypt but their fields of specialization are limited. We are not benefiting from the female work force." He asserted that the issue of development came before family planning and that what is happening now is that there are 1.8 beds per 1,000 citizens, which is a very low rate.

AL-MUSAWWAR: The truth is that when we thought of venturing beyond the ordinary political context in our discussions, we immediately decided that Hamdi al-Sayyid, the head of the Doctors' Union, should come, for a number of reasons: first, because of

the man's status in Egyptian life, second, because of his role and the stands he has taken, which everyone agrees about, and third, because he heads the biggest union connected with the destiny of the Egyptian people and their health. Politics, ultimately, consists of suitable housing, good health and fulfilling work for every citizen. Dr Hamdi al-Sayyid has been so kind as to grace the al-Hilal House with his presence and we are grateful for his quick response in attending and thank him for the effort and time he will spend with us tonight. At the same time, I can tell him that our colleagues in attendance will ask questions as they like on all issues, and Dr Hamdi al-Sayyid has informed me that he will greet the questions without embarrassment. Here I can stress the same commitment as in all the previous colloquia — we will be faithful to every word he says and every opinion he expresses. In order to start our discussions directly, we would first like to hear a somewhat integrated opinion from Dr Hamdi al-Sayyid on the health condition of Egyptians and his view of the problem of health in Egypt in general before we open the door to other questions.

Dr Hamdi al-Sayyid: Let me start by thanking you for this honorable invitation. I would like to state that I did not hesitate to accept it, for a very important reason, which is that I have been following up on the conversations that have taken place in the al-Hilal House in recent weeks with the utmost zeal, respect and appreciation. I really feel that you have introduced something new and worthwhile into the Egyptian press which we have been missing for many long years. I have observed that the level of this discourse is very high, very committed and very objective, and this is what caused me to agree to appear at once without hesitation. Here I must apologize because I was asked to appear at a fairly early time; my only excuse is that I am a man who is accustomed to working continuously throughout the day and I have no noons or afternoons — I consider that every day, indeed every hour, is a working hour.

AL-MUSAWWAR: We thank you for your elegant courtesy and would like to hear the general scope of the health problem in Egypt from you.

Dr Hamdi al-Sayyid: While as I understand it I am being asked to give a picture of the health situation of Egyptians as it exists now, I cannot isolate the issue of health and concentrate on that without looking over the situation of the Egyptians as a whole, because health is a general integrated situation and is not just an absence of illness! Rather, health is a state of environmental, social, psychological and health equilibrium and it must be greatly influenced by the various components of life under whose circumstances the Egyptian people live. Of course we all know the circumstances that the Egyptians are living under; those are no secret to us. Average national income in Egypt is still very modest. The development that has taken place over the past years has truly not realized the desired goal — this development which we sometimes talk about, saying that we have increased by 7, 8 or 9 percent while we do not take account of the distribution of this output or revenue which is increasing annually but is not distributed in a just manner, so that even these conceptions are meaningless, because they have no content: into whose pockets have these percentages gone? Among whom have they been reflected? This statement is not made in a vacuum, of course.

The same is the case with the various circumstances of civilization and the environment, and the connection of health as an element in the composition of man to other things and other issues. We are talking here about the issue of education and training, since they are among the most important basic issues; again, the state of education in Egypt is clear. The government is racing to be able to keep up with the level of compulsory education that exists now, which is 70 percent. We can then talk about the illiteracy rate

here, which is 60 percent among men and 80 percent among women, and state that we want to eradicate illiteracy among adults but have forgotten to eradicate illiteracy among young people, who are considered the main issue. The main issue is to close off "the sources of illiteracy," but this is a vicious circle; I believe that none of the talk about eradicating illiteracy among adults will be characterized by any sort of thoroughness if one does not talk about shutting off the "sources" first of all. Today we raise an important question, which is, how can we cover all the children of educational age and give them a complete education? This issue requires study, and of course I hope that in the course of AL-MUSAWWAR's colloquia an opportunity will be provided to discuss such matters. The same with the level of education: a large amount of the people who are educated here today lapse back into illiteracy. You can find people who estimate the lapse back into illiteracy at more than 40 percent and sometimes more than 60 percent; we do not know the truth completely.

How many of our children and how many of the 70 percent we are teaching lapse back into illiteracy because their fathers need them in the fields or in other jobs?

Naturally the issue of illiteracy in any country is firmly linked to the issue of health. The issue of the social level of the individual in Egypt is basically linked to the issue of health. Let me give an example of this: about 50 percent of our children of school age between the ages of 8 and 11 suffer from ailments of malnutrition, principally anemia. We can imagine children at this sort of age whose hemoglobin count does not exceed more than 50 or 60 percent. How can these children be healthy, productive workers or mature persons? How can we consider them a human investment or something contributing to production or anything else if the amount of oxygen reaching their tissues is less than 50 percent of the normal rate? That means that all their bodies, all their cells and all the development of their faculties is affected by this deficiency. Another thing which we might not be aware of is that in the old times we had the belief that children who were born received their full requirement from the mother in every respect while they were developing and growing in their mothers' wombs, and subsequently while they were suckling on the mother, and therefore the children received their full entitlements of proteins and growth components regardless of the state of the mothers' health. It has been proved that this is not true. Sick mothers can produce only children whose growth is deficient. The most serious aspect in development is brain development, the development of intelligence, because ultimately it is that which forms man and forms his capabilities. This growth starts at the third month and goes up to the ninth month; most brain cell growth takes place during this period, and when the mother is sick and exhausted, gives birth seven or eight times and lives at a nutritional level which is below the necessary level, of course she can produce only sick offspring. I wish that this issue would include the health dimension when one comes to talk about family planning or population issues.

AL-MUSAWWAR: Don't you believe that improper practices play a part in increasing the severity of the health issue in Egypt?

Dr Hamdi al-Sayyid: Yes. Let us take an obvious example, such as the spread of insecticides in this manner, on this broad scale. The insecticides cause pollution of the environment, which we are increasing every day without planning our solutions, without respecting vegetation, thus making the problem more complex. Then after that there comes the issue of sanitation, which may be the "main disaster!" Let me give you gentlemen a few very small examples: the pollution of food, whether through

drinking water, sewage, garbage or insects, is considered responsible for more than 50 or 60 percent of the deaths in Egypt — to the point where it could be said that if we take the whole health budget and spend it building sewers and providing clean water, it will be in our power to reduce the death rate in Egypt without a Ministry of Health, without a minister of health, and without doctors and the 12 medical faculties — that is, without all these great resources. This could happen in Egypt as a result of one thing — clean water and sound sewers. This issue is related to development and production. Perhaps you heard in the last and next to last sessions with President Mubarak that the sewers in Cairo alone require 2 billion pounds and that the water in Cairo needs 650 million pounds. We need to create a sewer system covering the whole republic. In Egypt, which has 47 cities, no more than 20 have sewers; the rest lack them. We know the true meaning of the phrase "without sewers" — it means that pollution increases every day, especially if there are filthy habits, alongside the piles of rubbish, the flies and the mosquitoes — all these things are piling up on the head of the Minstry of Health, because they are ultimately reflected in the health level of the Egyptian people. Therefore the statements that are made about the contributions medicine would make to the health level or the death rate is not on the order of the contribution that would come from civilization, urbanization, sewers, clean water, the elimination of rubbish, the fight against insects and the general things that really have helped improve the health level much more than medicines, physicians, hospitals or the like.

AL-MUSAWWAR: What is the population density's role in all this?

Dr Hamdi al-Sayyid: The population issue undoubtedly plays a big role in this matter. When the average number of people living in a single room in some sections of Cairo like Bulaq, Rawd al-Faraj or Bab al-Sha'riyah goes up to nine, how can they breathe clean air? How can they fail to be afflicted with germs and not infect the persons around them? For this reason, we find that the infant mortality rate in Egypt is high, totalling 89 per thousand; that is, out of every thousand births in Egypt between 80 and 90 children die. Naturally if we take into account the ratio is to be found in any developed country, we will find that that is as low as 10. That is to say, we have 10 times the mortality rate in the first year of childhood.

AL-MUSAWWAR: However, we know that the average life span in Egypt has increased the past 20 years.

Dr Hamdi al-Sayyid: The strange thing is that in spite of all that, there is no doubt that an improvement has occurred in the standard of living or the health level of the Egyptian citizen. There is no doubt in the past 20 years the life span has increased from about 42 to 57 years. The reason for the increase is the low infant mortality, and the reason for that is "greater" child care. Children can go to a mother and child care unit and to a doctor, they can receive care, and so forth. There is no doubt that a tangible improvement has occurred, but the environmental circumstances that people in charge of health in Egypt work under are extremely harsh and forbidding. In spite of that, we as a developing country, enjoy the best health system of any developing country. Health services are no more than 3 kilometers away from any citizen in Egypt; that is a distance that a person can cover on foot with no difficulty. The distribution of health services in our world today is to be measured by the citizen's ability to reach them. We are also the only country which does not resort to the system of supervising rural and small units through nurses, health aides or the like; we appoint doctors to these units. Thus, we are

the developing country with the greatest ratio of doctors to the population, and the developing country with the greatest ratio of health installations, beds, hospitals and so forth to the population.

I say "developing country" because we are many stages behind the advanced countries. Nonetheless, the general tendency and the general sense is that the state of health in Egypt does not reflect this quantity or broad spread of health services, for two reasons. First, the environmental conditions in which people responsible for health in Egypt work are extremely harsh, with, as I said previously, the sewers, the water, the garbage, the housing, the air pollution, the insecticides, many health obstacles, the high birth rate, women giving birth to seven and 10 children and not eating well, and whole families living out of the palms of their hands, with very low amounts of protein. The amount of protein that the Egyptian citizen obtains is below the desired level. It is protein that forms tissues, the brain, the cells and so forth. The second reason, which is a subject we are not embarrassed to talk about, is that the performance in the health sector is not at the level it ought to be. The performance is below the rhetoric about what it should be. Naturally, we are all witnessing the work the doctors do in the rural units, which is not as good as it could be. They can do better.

I am not blaming the health sector alone, but I cannot isolate the performance of the health sector from others, nor can I isolate it from the standard of living. I cannot isolate it from the provision of school meals for children. I cannot isolate it from behavior, I cannot isolate it from the church, I cannot isolate it from education, civilization, the environment or many related things. Therefore I say that the minister of health in any developing country is the victim — the victim of circumstances — and all the curses of the society are laid on his head. When cholera is widespread, for instance, the minister of health is requested to combat it and he is made to confront the responsibility directly. In my opinion, he is miserable. He continues to inoculate people against cholera while the origins of cholera lie in the polluted environment. That is, the minister of health is supposed to review all the facilities that pour their sewage into the water. When we searched for the sources of Nile water pollution, we found no less than 70 or 80 sources of pollution, from Aswan to Rashid and Dumyat, including whole cities that poured their sewage into the Nile water, in addition to many factories that throw their refuse into the waters of the Nile.

I can find no better definition for this poor Nile, which has become wretched today, than the one Mr Ibrahim Shukri made when he spoke and said that in olden times the Nile would protect itself. Why? In the flood season, it gave its spirit a complete cleansing of everything with which it get polluted throughout the year, such as the floats, boats, and the human masses that urinate and defecate into it; the Nile would come during the flood season like a broom, cleansing itself of all that. However, since the curbing of the Nile following the construction of the High Dam, there no longer are any floods, the Nile has become miserable and wretched, and no one is looking after it.

In conclusion, the minister of health is bearing all these heavy burdens. He is told, "You have bilharzia, you have this, you have that," although we know full well that bilharzia could be eliminated if everyone refrained from urinating and defecating alongside water resources, to stop the bilharzia in Egypt. This would require a change in the irrigation system. However, can we tell the peasant "wear boots on your

feet?" That's not possible. He digs a channel, fills it with water and floods his land. This water is full of snails. These snails are afflicted with bilharzia, the citizen goes down to take a bath, to wash or whatnot, his friend urinates or defecates alongside the water, and the bilharzia ova go down, hatch and complete their cycle, then come the (cercaria) which bore into the skin of the people they come up against, and the cycle starts again inside their bodies. Therefore bilharzia will be stopped if people stop urinating and defecating alongside the water and also do not go down in bare feet. Is this possible? This will require a general change in people's behavior, in the system of irrigation in Egypt, and in the drainage and sewer system, and these are very complicated problems. It has become necessary for the minister of health to go to a number of places from time to time to carry out snail eradication programs.

AL-MUSAWWAR: We are a people with an ancient civilization; why don't we see cleanliness taking deep roots in Egyptian behavior? We do not want people to be dealt with like sacred cows. If we fall prey to error, we must admit it and discuss it.

Dr Hamdi al-Sayyid: I will give you a very odd example. I visited Indonesia. Indonesia is a Moslem country, except for very small groups of certain other religions. I was told that the thing which is very conspicuous in Indonesia is the extreme cleanliness. It was so great that when I visited the ambassador, who had two workers, he told me, "Imagine, this lady and that man bathe three times a day!" Part of the nature of the Islamic religion is to promote cleanliness. In the Middle Ages there was a bathhouse in the Farsay Palace the likes of which did not exist. You would go to visit the Alhambra in Andalusia and would find bathhouses with hot and cold water in the ninth, 10th, 11th and 12th centuries, so cleanliness is a basic part of man's makeup in the Islamic environment. What happened in Egypt? I do not know. Where is the role of religion? I do not know where the role of the mosques is, though they are spread about in abundance. I do not know where the role of our religion, which implants and urges cleanliness, is. I do not know. Nonetheless, I consider that this society is not as fully concerned with cleanliness as those of developing countries that I have visited. Cleanliness does not mean pomposity, although you might wear the best clothes; it is behavior. You can wear tattered rags that are nonetheless clean. Water is abundantly available, and there are the resources for cleanliness, but who is responsible for this behavior? I believe that this is the national issue that merits discussion at the highest level, because the reasons for health abuse and a large part of the reasons for the health in Egypt is the issue of cleanliness.

AL-MUSAWWAR: Is there enough publicity about this? Is the role of the media in coping with this adequate? We have been calling for this for many years and have not yet obtained any results.

Dr Hamdi al-Sayyid: I agree with you about that, but I have a very important observation. When we traveled to Britain we were dazzled by the level of cleanliness there. Everything was clean. They say that the British people are essentially a clean people and when you go to any park you will find a small sign on which it is written "Throwing trash prohibited — fine 10 pounds" and the sign is 150 years old! Of course when the British began their civilization the problem of cleanliness was one of the concerns of the public, because the lack of discipline, the opposite of being disciplined, is something normal in people — the basic thing is that people set out and do what they want. Patterning your behavior and proceeding in a general framework is an artificial thing that must be imposed on you. To some extent, the role of punishment is no doubt relevant here; I say that when they started that system

everyone who discarded something actually did get a fine. This penalty is carried out and applied to everyone. After a little while it becomes a habit, and after that fathers warn their children, "Be careful not to throw anything out or you will be fined." After that it becomes general social behavior and becomes part of the heritage, whose violation is a perverse act.

AL-MUSAWWAR: There are many negative features in society. Consequently, there must be a free press. However, you are angry with the press. What exactly is your position on the press and what rules do you consider appropriate?

Dr Hamdi al-Sayyid: I was expecting this question, because I put my head in the lion's mouth. Nonetheless, I have a view on this which is very clear, and I would like to be most truthful and sincere with you gentlemen. In the days of 'Abd-al-Nasir, with whom I was somewhat close — naturally I was close to the Nasirist experiment, since we were young, we were part of the Nasirist experiment from its start, I graduated in 1952, that is, at the beginning of the revolution, and lived through the experiment, with its length and breadth, with its negative features and its positive ones, and I also lived through the experiment of al-Sadat from beginning to end. I witnessed a very strange assassination, not the assassination of a person but the assassination of the values of this country. I wonder: we continued to adhere to 'Abd-al-Nasir for a year, until 15 May [1971] came, and then we started to dissect 'Abd-al-Nasir's era, started to talk about the negative features, began with the sequestrations, then the torture, and ended up by turning the table over on 'Abd-al-Nasir himself, on grounds that he was a catastrophe for Egypt, and all that he left behind were the 1967 defeat, torture, mistreatment, and so on and so forth. We eliminated a period which I consider to be one of the most glorious and brightest periods in Egypt. I am prepared to discuss this issue all night long. I was there in 1952 when all Africa and the African countries were colonies, I was there with the revolution of freedom that started in Egypt, I was there when Egypt was the torch of freedom in the whole Arab, Islamic and African region, and I look at 'Abd-al-Nasir, in the historic sense, as an asset from this standpoint. Therefore the fact that he imposed 15 sequestrations and 13 cases of liquidation and arrested 10,000 persons, 20 of whom were tortured, I will say that these are things that history will not pause over for a moment and will not remember. When the history of 'Abd-al-Nasir's era is written, it will be a history of the age of giants — 'Abd-al-Nasir, Tito and Nehru, who started the cause of nonalignment and entered into struggles with colonialism, twisting its neck and creating the nonaligned bloc, which came to have a view of its own. I believe that this is 'Abd-al-Nasir's contribution, which I must polish and clean and keep in mind, and I should not mention 'Abd-al-Nasir's era just as one of evil or misfortune — that is the height of folly.

Today I would like to give you a statement on all the discussion that goes on in the press concerning the two eras. When I come to al-Sadat's era, and say that that era was also bright. I differed with him toward the end of his days — I differed over a number of things, I got into discussions with him, and he listened to me but was not won over. However, I appreciate him as a patriotic man who did much for this country. I say that if Anwar al-Sadat had done nothing for Egypt except 1973, he would have paid his debt to this country in full.

When I travel abroad I find that al-Sadat has a brilliant image in the world as a moderate, balanced leader of value. I say that much of the distinctive position we have acquired recently was through al-Sadat's effort. When you go to America or elsewhere today, you find that the balance has changed, having been totally oriented

toward Israel, there has come to be a different understanding of the other viewpoint, and the person responsible for that is not our oil brothers, the person responsible for that image, which has improved in the media sense, internationally, in Europe and in America, is Anwar al-Sadat. When I say today that the Egyptian economy, in spite of all the convulsions that have befallen it, nonetheless has undoubtedly begun to acquire some confidence and has furnished an atmosphere which permits money to be moved out from the floor tiles and sent into investment, here I am not saying that the investment has been totally proper, and I am not saying that it should not be directed or that one should refrain from reorienting it; suffice it to say that the Egyptians abroad remitted 2.5 billion pounds last year, which, before that, used to stay in banks in Lebanon and elsewhere and did not come to Egypt. Now it has started to be remitted to Egypt, and has contributed to some development. You will tell me that that is consumerist investment, but I can say, suffice it to say that it has come into Egypt, whether in the form of commodities, investments, or anything else.

Al-Sadat managed to create an atmosphere that put people at ease and gave them confidence over their money, so that everyone brought the money he had out from under the floor tiles and started to invest it.

What has happened since Anwar al-Sadat's assassination? What has happened since his death is disgusting. I hope you gentlemen will permit me to say this and not get angry with me, but it is disgusting to the spirit — Anwar al-Sadat, about whom the whole world used to talk and applaud night and day and whose table they ate at — don't be angry with me — many of the people who benefitted from his existence, the tables turned on them in 2 or 3 months, everyone who made a fortune in Egypt became a thief, and the millionaires — by the way I am not one of them, am not related to any of them by any connection, I haven't earned anything, I do not belong to a class that owns anything, I have no interests, I am just talking as a citizen and an observer of what is happening on the stage — there are groups that say that someone has evaded taxes, it has become apparent that they set up a maxim "300 millionaires arrested in Egypt," everyone who has anything in Egypt has become a thief, and we have reached a situation that is very different from 1961. At that time, when we said "nationalization" and raised the slogan of socialism, redistribution of wealth and limitation of feudalism, that was to be accepted. To tell people "you own land, that is correct, but we will take this land in order to realize justice, you have inherited it from your family but others have not inherited anything, the agricultural land is limited, and it must be redistributed, "or" you have factories that we want to nationalize on behalf of the masses," [that was to be accepted].

Today, though, we are doing worse than that — we are saying that everyone in Egypt who has property is a thief and must prove the contrary. The rule has been turned upside down. Every official in Egypt is guilty until he can prove that he is innocent. Everyone who has wealth in Egypt is a thief until he proves the opposite. The scales have been turned upside down. Of course this is not the period of the trial which I say, in spite of what is said, was democratic and a great testimony to the validity of the Egyptian judiciary; rather, this is, in reality, a trial of Anwar al-Sadat, whose blood has not yet dried, and I say that Anwar al-Sadat — with whom I differed over many of the things he believed in — gave his life for Egypt. If he had lived 3 more months Egypt would have been ruled by terrorist groups.

However, his assassination came at a time when the terrorist organizations and formations had not yet matured. Let us not forget that 100 people almost took over the

Governorate of Asyut. If there had been 100 people in each governorate, they would have taken over the 27 governorates of Egypt.

I believe that al-Sadat was assassinated -- which was God's decree -- to protect Egypt from terrible fate that would have come sooner or later. You may tell me that the regime encouraged them, but I am speaking about a thing that actually happened. Al-Sadat's blood has not dried and we have committed a great act of injustice against him. This has been stated on cassettes that were smuggled abroad. Anwar al-Sadat, whose image before the world we benefitted from, as a shining image of a man who wanted civilization for his country and security for his region, who managed to put Israel in a defensive position for the first time, the man who created a beautiful image for himself everywhere, who is distorting that now? The Israelis? Our oil brethren? Of course not. It is we who are distorting the image. I will not stand in the way of anyone who wants to criticize any condition, but can I condemn a whole age? Can I condemn a regime? Even the /Society of/ Faith and Hope which the poor lady /Jihan al-Sadat/ raised up and through which she did something for Egypt, and which I believe to be a noble project -- it is said that the country was mobilized for her. Mobilized for whom? All of you should go visit Faith and Hope. I visited the project and am proud that it is at the level it is at. I am proud that we have something civilized at this level that was established especially for people disabled in war. Let me familiarize you with the recommendations I send by the dozens every day for disabled and crippled children to get treated there. When we decided to honor her on the most recent Doctor's Day, someone got in touch with me and told me "How dare you honor her? What is the value of Faith and Hope, which treats no more than 35 patients?" I told him, "I am going to honor Jihan al-Sadat, do you have anything against that?" I told him, "This lady was active in public work, and I am not talking about anything else, I am talking as a citizen, I am a doctor, and I have witnessed her efforts from the days of 1967 then 1973 and after in the field of public work. I can say that this gracious lady has offered the country very much in the field of medical, humanitarian and benevolent work." It is said for me that all of this rejection and denunciation should appear, 3 or 4 months after her husband's assassination. I believe that no one any longer dares to defend her or Anwar al-Sadat today. In whose interests is this?

Are we a country that has been turned into a bunch of ingrates? A group of cats that want to eat their offspring? Is it very demeaning to Egypt to be proud of Anwar al-Sadat? Is it very demeaning to Egypt to be proud of Jamal 'Abd-al-Nasir?

In whose interests is this? One person told me, "You are defending deviation!" Who said that? Who said that I am defending deviation or sloth? The fact that there is deviation does not mean that one should condemn the regime. The fact that there is a group of thieves in Germany by the name of Meinhof does not make it legitimate to accuse every German of terrorism. Does the fact that there are Red Brigades in Italy mean that Italy is all Red Brigades? The fact that 10 senators in America took bribes from oil countries does not mean that the whole United States Senate consists of deviants. No one would say that. You cannot condemn a regime or condemn an era because of a deviation here or there. We in Egypt know what the word "deviation" means.

I have a stern rebuke to deliver to the press. No sooner does the press find a citizen who is condemned than it deals with him destructively, and let him prove that he is innocent! Even the poor man sick with angina in al-Ma'adi Hospital ('Abd-al-Razzaq

'Abd-al-Majid), and I believe that that man, and here I say this as testimony to God, was a man of integrity, who made efforts, erred and misjudged -- all right, every man must try, of necessity he will not succeed in everything, but I believe that he is a man who has been extremely devoted to this country, and he is a man of integrity - today it is said that he is a deviant and conspired with Rashad 'Uthman, and he has not been permitted to defend himself. The strange thing is that the public prosecutor defended him and issued a statement to that effect. After that the papers descended on us, finding fault with the public prosecutor and saying "This man returned money to Rashad 'Uthman, why was it returned so quickly?" That is, this is an attempt to stir up dirt against a man against whom the office of the public prosecutor said there was no basis for filing a case against, and the office of the prosecutor is the indicting authority - that is, he was found innocent not by the judiciary but by the indicting body. Nonetheless this regime still has to be tainted and every official still is tainted.

The result of all this is that this has all become an obstacle today to any official making a decision. Will a given minister or a given official anywhere be able to put his name to a piece of paper without lengthy conversation, consultation, confirmation, review and wasted time today?

I made an attempt, with an official, to get him to sign a decree that was in the public interest and told him that this decree would save the country 5 years. He told me "That's not my job." I told him, "It will save 5 million pounds." He told me, "Not even for 10 million." He told me "Be patient until we can confirm and ask. Otherwise, in 5 years, when they brand me a criminal, who will defend me?" That's true -- who will defend him? I wonder whether an accused person is innocent in this country until his guilt is proved, or is the accused person a suspect, a thief, a murderer and a deviant until it is proved that he is innocent? I would like to know where the standard by which you measure things or by which we as a people measure things is. Now, can you believe that there is a person who was maligned on the pages of the papers for a whole month, then his innocence was determined in the end, and you want other people to believe that he really is innocent?

It will be said that that is patronage, "zucchini," and other such talk that we repeat in situations like this.

Isn't there a code of honor that says that this accused person and his reputation must be protected? Who will be responsible for the death of this sick man in the hospital (he meant "Abd-al-Razzaq 'Abd-al-Majid) if this man who has had a heart attack, whom I was summoned a week ago to see in the hospital, because he felt blatantly oppressed because no one was standing by his side, dies? Is this our mission? To tear every official apart as we wish?

Someone whom al-Sadat treated well - I do not want to mention the names of the people al-Sadat treated well and whose hand they bit - but someone whom al-Sadat treated well speaks well of him, while it has become necessary that someone whom al-Sadat did not treat well settle his accounts with him. Someone goes to prison, I say that honorable people and people who protested against al-Sadat's approach while he was alive, came to this room, and spoke here, I have not heard any of them today rejoicing, cursing or claiming to be a hero.

Rather, today I see everyone holding his pen after he has unsheathed it like a sword, and playing the part of the hero. Fine, where were you, boss? Where were you?

He will reply by saying "I didn't get a chance!" No, someone besides you was given the chance, spoke, talked and went to prison. Where were you? Most of the writers and politicians who do not denigrate 'Abd-al-Nasir's era are ones who went to prison in his time, and there are many of them. Nonetheless, they have a commitment to the language. None of them measured 'Abd-al-Nasir by the amount he gained or lost - they measured him, rather, by the amount he achieved, the sacrifices he made and his negative aspects.

Today, when you tell me that young people have become frustrated, I tell you that that is because you have not left them any values they can take pride in. Tell me, Egypt — what is Egypt if I do not have any values of which I can be proud? Shall I be proud of the pharaohs? Shall I be proud of Ramses the First? What shall I be proud of? You have not left me with any values I can go back to. I say that Egypt is thus and so, this is its struggle and these are its sacrifices, but everyone has become tainted.

Today, we are living in a serene, free state, a healthy climate, with freedom of the press, but nonetheless we sacrifice someone and destroy someone else every day. The people are delirious, we believe that a solution to our problems lies here, and we sit down to observe it all, but where is the production, the industry, the cotton, half of which is not exported, and the agriculture which is deteriorating as its prices rise? Can this be set right by administrative decrees, by pricing, by temporary decrees, by organization and rationalization? No. One has to work.

In Britain, for example, Mrs Thatcher said that the British economy is flabby, in the sense that many economic installations are operating without any profits to speak of and have problems with labor and wages. She said that any installation that did not realize an income would be shut down, and, in the first 2 or 3 years, 1,300 factories were shut down. People rose up against her and they expected her to lose the elections, but she said "I have 5 years in which to govern Britain; these bad economic measures will take the first 3 years of the term, but the people will see returns from this policy in the fourth or fifth year, to the point where I will be able to win a majority in the next elections." Here I would like to know the strenth of the present government. I would not like to state here that it is not supported by a strong party; I say that party and political activity in Egypt has not yet matured. The government needs to make this sort of decision, or the policies need to have a strong party to adopt them, promote them among the people and defend them. Will the government be able to impose escalating taxes on luxury items? Will it be able to resort to the method of cards and card distribution, with everyone just getting something close to what it is suggested he have? Will the government be able to rid itself of many of the notions it has not yet been able to? When I say "treatment free of charge," where will that come from? I cannot pay for it. I spend some money on health, but that is not sufficient for free treatment, indeed is not sufficient for preventive activity. Nonetheless, I raise the slogan of treatment free of charge — I tell people, "Impose duties so that you can acquire revenues which you can spend on service and improved service." They say, "How?"

That is a violation of socialism!

Is that a violation of socialism? Who said it was? Does socialism mean that we should oppress the work force, distribute people, appoint 50,000 workers, make the public sector bear the accumulating burdens of unemployed people and let factories operate at a loss?

One must take a realistic view of our future problems. Is it in anyone's power to make this kind of decision, which entails a large degree of suffering for the people?

AL-MUSAWWAR: As far as the subject of the press goes, we are in agreement with your view on this matter, all in all, and I think that AL-MUSAWWAR's position, which is that it is calling for what it is calling for, is completely clear on this. However, we have got the feeling from your statement that you are opposed to free treatment. What in your opinion should the approach be with regard to indigent people? What is your opinion on the subject of free treatment?

Dr Hamdi al-Sayyid: I am not opposed to free treatment. I say that the government has raised the slogan that all of our health installations should be free of charge. That is a good statement from the theoretical standpoint but I make a different claim, which is that no government in the world can provide totally free services, neither in the East nor in the West, neither Russia nor America, and these are countries that have very massive reserves and dispose of a great deal of money. America spends between 12 and 15 percent of its national income on health, in contrast to Egypt, which spends about 2.5 percent of its budget. This is a difference, of course, betweeen the health level we are suffering from and the health level they are suffering from; I can say that the government has a permanent commitment which it cannot abandon, and this takes top priority. The first commitment is to preventive [medicine], the responsibility for preventive medicine in its totality, be that inoculation, health in schools, mother and child care, immunization, environmental care, health surveillance, food surveillance, or health guidance — this is the responsibility of the government in its totality in every country of the world, and it is free, because the preventive aspect is the aspect which realized the greatest returns in the context of health for the citizen, while the returns that treatment realizes on health are very small when compared to preventive medicine. After that there come the services, what are called first aid and emergency services; for example, when someone demands first aid at night or in the day or is hurt on the street, I cannot look in his pockets first of all to see whether he has money or not so that I can treat him if he does and leave him if he does not - leave him to bleed to death on the street. In the East and the West, treatment is provided first, he is given aid second, and after that his situation is looked into, as to whether he should subsequently be treated for a fee or be treated without a fee, according to his abilities. The third system, which is basic medical care, is the service the rural units provide, for example treatment of endemic diseases, examination of students in schools and mother and child care. The government guarantees all these services free of charge, and this is known as basic preliminary care. There remains one enormous sector, which is the treatment sector. Treatment means that I am sick to the stomach, have tonsillitis, or have gastritis and want to get treated. The government is just committed to treating the indigent, who cannot pay; other people must contribute to treatment services, in accordance with their incomes. The optimum system for this is what is called the health insurance system. What is health insurance, or what they call social health insurance? I for example have a salary of 220 pounds and have an employee whose salary is 35 pounds. One percent, or to 2 and a half pounds, is deducted from my salary. One percent, which is equal to 30 piasters, is also deducted from the employee's salary. The government pays three times that amount, or the employer does, and the two of us enjoy the same service. Here I am contributing against my income and he against his, and ultimately the two of us are equal in terms of health service. That is a form of mutual treatment and solidarity. That is the optimum system which is applied in all the socialistic countries in the world, such as

Britain, where an amount is deducted from each person's income for social insurance against illness, old age, disability and unemployment. Therefore we find that health enters into a single vehicle for social insurance; there the person is insured, in the sense that if he suffers a disability or is retired, he gets a pension, if he is sick he is treated, if he is injured in an accident he gets compensation, and so forth. This is called a unified insurance system. When the revolution took place and the socialist decrees were issued, the notion began to appear that health insurance should be applied, decrees were issued to that effect, and health insurance actually was applied, in Alexandria. This insurance remained confined for a period of 10 years.

Today the insurance system has expanded to the point where it embraces a total of 2.5 million citizens, no more. There was a plan, which we studied on assignment from al-Sadat, a plan to expand health insurance among the people in general; we found that in order to get insurance to the citizen by the health insurance system by 1990, we would need to have annually increasing investments starting with 500 million pounds the first year and going up to 800 million pounds the last year; that is, at the end of 1990, in order for the government to spend the sum on social insurance that would be added to what would be collected from the citizens, that is, their share of the quota, it would take 800 million pounds. Of course that is an optimum health service system. When one lacks a reasonable system at a good level, the following happens: when one says free service in free Ministry of Health hospitals, each bed, the best bed in a university hospital, is allocated a sum, which does not exceed 500 pounds a year, to be spent on medicines, food and medical accessories such as X-rays, laboratories, analyses and so forth. Some Ministry Of Health hospitals pay 300 or 320 pounds per bed. I would like you to imagine that the government spends a pound a day on beds as money for food, medicine and treatment, and one should also observe that prices are constantly increasing. The result is that the following happens:

1. Starting the final third of the year, there is no budget for food or medicine; as a consequence some beds go empty!

2. As a result of difficulties in service, such as shortages, patients consequently remain in bed longer than they should, and the turnover of beds, [and] availability of adequate medicines or X-rays lag because the services for patients are not adequate. In addition to that, operating rooms are not clean, wounds get infected and patients continue to take more medicines. There are not enough antibiotics and the balance of medicines is deficient. People are forced to inform patients to buy medicine at their own expense, operations become free in name only, like schools, where the student takes special classes that costs him more than the free ones do, the patient is forced to go to the doctor in his clinic to get moved to hospital for a specific fee so that he can get attention, and we are starting to get into a state of chaos and deviant behavior that has no beginning or end. That is the natural situation, because of scarce supply and increased demand, which lead to the emergence of a black market and consequently the creation of scope for deviation.

AL-MUSAWWAR: In the context of doctor's fees, and treatment fees in general, treatment with medicines at inflated prices may be the problem. The problem is the head of the Pharmacists' Union. There are inflated pharmacists' prices, in particular for medicines that have to be prepared inside pharmacies; these are high and absolutely illogical in terms of the materials that make up their ingredients. Is there

a chance to try to remedy medicine prices in general in this context? The second part of the question is the phenomenon of hospitals as investments, which have started to become abnormally widespread as purely investment projects in which the sector of major doctors or people with rare specializations that you have referred to ordinarily take part.

Dr Hamdi: Allow me to drop the subject of medicine, because it has many dimensions; let us talk about private hospital projects and investment hospitals. We in the union have suffered distress over the chaos in clinics. We have diverse standards for clinics and diverse standards for hospitals. There are dispensaries, there are clinics owned by universities or individuals, there are orderlies running dispensaries, there are unqualified doctors running clinics, there are doctors who write, over their clinics, "internal medicine, obstretics, surgery and antiseptics," and there are others who say they have received higher studies from whatnot university! We in the union have discovered that the law does not deal with this sort of case in any way. We have been told that this is the union's responsibility. Therefore we presented the draft of a law titled "The Law on Private Installations." The day before yesterday the Council of State gave agreement to the executive bill on this and the law is about to be put into force. We have insisted that there must be specifications, a recording registry, and ongoing inspection of private clinics and private hospitals, because we have found a very serious discrepancy in prices in private hospitals. The draft was connected to the fact that every clinic should be registered with the union and the Ministry of Health, there should be inspection, there should be a serious approach to suspending permits, what is written on the shingle of a clinic should be available, any clinic in violation of that should be shut down, and so forth. With respect to hospitals, we have set out a number of conditions, among them that there should be specialized doctors, physicians, and so forth. We have spelled out the fees for treatment, which was a very touchy issue since we said that fees in private hospitals should be stipulated as hotels are; what is a private hospital but a sort of hotel? I break hotels down by classes. The Ministry of Tourism sets out a price system for each class. The same thing goes for hospitals — I agree to the formation of a committee to set prices made up [of people from] the Ministry of Health, the governorate and the union, along with the private hospital owner, and we agree on rules for computing hospital rates. There is no doubt that private hospitals, by all standards, are not social, humanitarian institutions - they are economic installations, in the sense that money is supposedly invested in them for the sake of realizing a profit and realizing a return that will allow for development, will allow for replacement and will allow for progress. However, if this sort of thing does not exist there will be absolutely no private hospitals, and anyone who has a hospital will turn it into something else - a hotel, for instance. Is it in people's interests for these private hospitals to disappear?

The question on that is that since public treatment is still deficient and inadequate, then it would be in people's interests to have the greatest number of beds in private hospitals. Why? The law of supply and demand. The more demand increases, while supply is low, the more owners of private hospitals will resort to price increases. If we flood the market with private hospitals, beds will be available, we will start to have different levels, and this will help reduce costs. We agree that there will be a standard, a specific percentage of net profit of such-and-such percent for hospitals, which will be adequate for replacement and so forth. This will be the pricing that will be reviewed every two or three years according to the inflation rate. It will remain posted, in plain sight, and will be authorized by the

relevant director of health. A direct question arises, and this is, is it necessary that we have hospitals in an investment context? The answer to that is of course, categorically, yes. Why? Here I can say that traditionally Egypt at some time was the place which every Arab or African in the area who wanted treatment would visit and make a pilgrimage to, because Egypt had a deep-rooted reputation since 'Ali Pasha Ibrahim, and had very massive expertise, until a new era dawned, 10 years ago, the era of medical technology. Medicine today no longer means a good doctor and a stethoscope — medicine today has come to involve equipment whose costs in some cases come to half a million pounds.

If it lacks this, Egypt will lose a basic element of competition in the region, the element of medicine. Today, when we compete in medicine, we are competing with Saudi Arabia and the hospitals in Saudi Arabia, with Britain and the hospitals in Britain. I have been competing with Beirut and the hospitals in Beirut. We are competing with Greece, which has attracted a very large number of the workers in the region today. Arab citizens want treatment in a good place which is furnished with the best equipment. I can say that there is no method of treatment in the world, no means for treatment, no use of some item of equipment for treatment (even if it is out of order) that does not exist in Egypt, along with dozens of Egyptians who have been trained in it in Egypt. There is a laser everyplace. This is the last word in the realm of treatment. I once told President al-Sadat when he was discussing normalization and the rest with me, I told him, "They showed you an instrument and said that it was the most modern diagnostic instrument. You appeared on television, you and Mrs Hihan al-Sadat. They said that they were showing you on a special computer, and so forth. This instrument existed in a private hospital and in al-Qasr al-'Ayni for 4 years, and there are nine in Egypt now. That is, we do not lack expertise or trained people in Egypt because everyone travels abroad two, three, four or five times a year, attends conferences, reads periodicals and attends seminars. No newspaper has reports on less than four or five vocational conferences, because there is an intense incentive, which is the incentive to be superior, and every doctor wants to be better and acquire everything that is new. One thing remains, and that is financing. Ther government is not financially able, so therefore you now have to get into financing carried out by companies or bodies. Today the cost of a hospital like the al-Salam hospital comes to $60 million. Who can pay $60 million? The Arab Contractors' Hospital cost more than 20 million pounds! Who can pay this, except for a large body that can invest? Now you can go to the Arab Contractors' Hospital or the al-Salam Hospital and see every instrument or item of research that you can get elsewhere in the world. Doesn't that entice people who want to work in medical tourist activity? I can say that Egypt must perform this civilized role. There are people who will say, "You are providing this equipment in these hospitals but are depriving the Egyptians of them." Of course the issue of the ability to pay and the indigent arises here. Am I, as the private sector, supposed to acquire an instrument worth 7 million pounds, a seismic instrument, which is considered the last word in the realm of radiology treatment, of which there are two in Britain, five in America, and a single one in the whole Middle East, which treats tumors, because it can penetrate tissue, focus on an afflicted area and kill it — the private sector has managed to acquire this sort of instrument; shall I tell it, "I don't want it?" How can this sort of instrument be made available to Arab citizens who can pay but not to Egyptians? I will say that it is the government's duty to provide the same thing. Today the government actually has started to invest its money. For example, there is a hospital where the government has invested 60 million pounds that is being erected at 'Ayn Shams. It will be the latest thing

available in the era in terms of resources. This is the government's function, to provide one or two hospitals or one or two instruments for treating people who cannot pay, but doesn't the person who invests 60 million pounds in a hospital, and does not invest that in carbonated water or Schweppes deserve the applause and praise from us that someone who invests his money in carbonated water deserves? How can we not encourage such an investor in the hospital sector, working to bring hard currency to Egypt's treasuries every year, able to get the whole Arab area to be treated in Egypt, and tell him, no, what are you doing? I believe that the process of investing in the field of hospitals is very desirable, for a number of reasons:

1. It brings new technology into Egypt.

2. It rains doctors.

3. It prevents a drain. For the record, we spend 31 million pounds a year on treatment abroad, and none of that is received from the government by sick people for treatment abroad. If this money came into Egypt and were spent inside Egypt, wouldn't that bring savings to the domestic economy?

AL-MUSAWWAR: No one disputes that, but, at the same time, I believe that the union must play a part, which is to borrow from the bank to create special small units or get doctors to participate, by means of young doctors who have acquired a doctorate and cannot find a place to work, by way of contributing to solving the problem.

Dr Hamdi: So far we have formed a company called "The Medical Profession Hospital Company." It will invest money that actually is available. We have started getting help from various bodies to build clinic complexes in various sections and governorates. This project requires that each clinic consist of a complex of clinics in which basic medical care services which will be offered to the citizens free of charge will be available and in exchange the governorates and the localities will give us land at a token price - not at a price of 1,000 pounds per meter, then tell me "Make a complex of clinics conducting examinations for 1 pound." We raise the condition that we be given land for token sums so that we will be able to save on costs. The proposed project is to erect a small hospital over this complex of clinics, a 20-bed hospital, since many people's problems are concentrated on obstetrics, tonsils and gastric problems.

As regards delicate operations, such as heart and other operations, it is not reasonable for that sort of operation to be conducted in this sort of condition, which is like a trench. This is all based on the hope that we will succeed in establishing such a system of hospitals over a number of years. We are now looking for bodies that will give us loans and grants, such as the American aid program. This is all in hopes that when this activity is expanded it will subsequently be possible for us to set up a private health insurance system, in the sense that when we have such a system of hospitals we will be able to tell people that we can admit a class of people that will be disposed to receiving integrated service in the context of private treatment. At that time some people might come to us because they do not like the government health insurance system, where the lines are long, and because they want to be free to choose the doctors who will treat them.

They want to be free to choose the hospital where they will be treated; it will be possible for me to provide this sort of citizen with such private services, and this

will result in eliminating much of the people's suffering because many people might accept this new system if they realize that they will pay 1 pound for treatment per year for an accident or emergency. I, as a union, will rely on government cooperation in my new project. I have sent off to 14 governorates, and have received answers from just three! I wrote to them again, telling them that I was offering them something that would help solve the treatment problems of citizens in their governorates. One should bear in mind that these governorates have faculties of medicine and good young people with doctorates, a high degree of expertise and good performance levels who are ready to work directly for a token fee. The service level is good and it will be within the citizens' ability to pay. In addition to that, we will be making an intense effort to keeping clinics open in the afternoon. We have applied this system in Heliopolis; we have seven afternoon clinics in health bureaus and health centers. I do not believe that I have any problems in Heliopolis, because that has big service outlets, the Ministry of Health and the armed forces, in which professors of medicine from 'Ayn Shams and al-Azhar might be working. The armed forces have applied a very good system, opening their hospitals in the same manner to serve citizens in the afternoon. These are the untraditional methods that must be broached in order to solve an extremely complex problem like that of treatment in Egypt.

AL-MUSAWWAR: What about treatment fees in doctors' clinics?

Dr Hamdi al-Sayyid: I am not satisfied with these. We have repeatedly given warning of the seriousness of this situation, through letters, statements and all the means we possess. We have said that this is not right.

AL-MUSAWWAR: Especially since there are patients who come in from rural areas whose material circumstances are poor.

Dr Hamdi al-Sayyid: There is no priesthood in medicine. It is the only profession which is open to everyone. I can stress that there are dozens of people, in fact hundreds, for each big doctor in the capital, who can treat the same condition at a quarter of the price the big doctor gets. However, people in our country suffer from something called fame. When you know that a doctor is famous, you will run after him, swarm about him and put pressure on him. The question of fame enters into everyone's head. Then there is another issue, which is that of frequent visits to doctors even when there is no illness. People who cough go to the doctor; if they bear with the cough 2 or 3 days it will disappear automatically, but what happens is that people who cough go to doctors for respiratory diseases, although with a little medical knowledge anyone could treat himself. The question is connected to the degree of maturity in society. The solution is awareness. The question of pricing requires awareness among people. It is not a question of dealing with doctors but of dealing with butchers and grocers. Awareness causes people to boycott those who increase the prices they pay. I wish that people would not run after the big medical professors, but it seems to me that the issue is connected to a show of pomp and wealth. Some sick people travel to the end of the world, get a car that rents for 30 pounds, then complain of something trivial that does not deserve such running around.

AL-MUSAWWAR: For every doctor who gets 20 pounds there are 15 out of work. What is the union doing about this?

Dr Hamdi al-Sayyid: There ought to be publicity to guide sick people. The problem lies in the means of publicity. We are thinking of putting out a book that will have information on every doctor, his field of specialization and his expertise.

We will be helped in this when the process of registering clinics begins to be applied. However, we must not forget the poor administration in Egypt. The union is part of Egypt. Let me repeat that there is no substitute for expansion in service outlets, that is, increases in the number of clinics, improved health insurance and improved performance levels in public hospitals. That is the only solution. It has been proved that any other solution, based on agencies, investigations and the police, will not achieve success.

AL-MUSAWWAR: Many doctors get fantastic sums and evade taxes. They constitute a pressure group in regard to taxes. Isn't there some way to have a sound, respectful situation on the part of the doctors and their taxes?

Dr Hamdi al-Sayyid: There is a long history of blunders on taxes in the profession. We have not yet reached any sort of balance. There is no doubt that some doctors try to evade taxes, but others are subject to prosecution and surveillance by the tax agencies in Egypt, as if they were really wealthy, though the people with the wealth are merchants and skilled workers.

In a single campaign in one month, the Tax Department collected 18 million pounds, when it reached a settlement with some taxpayers.

The Tax Department collects 12 million pounds a year in taxes from professionals, including lawyers and engineers. Among these, doctors paid 7 million pounds.

The Tax Department, in order to settle old disputes, has focussed all its efforts on professionals. I told the president that the Tax Department should go out, see a newly constructed building that cost 2 million pounds, and hold its owner accountable; thus, collection should be at the source. It is certain that as regards commercial transactions anyone can get a million pounds by selling a plot of land. That is a legitimate gain, and the government must receive what it is entitled to from it.

AL-MUSAWWAR: Let us specify the dimensions of the problem between the doctors and taxes.

Dr Hamdi al-Sayyid: The endemic problem may be summarized as follows: there is a stable relationship. The doctor is always prosecuted; the doctor cannot hide the volume of his transactions, because his clinic is always open and anyone can go into it and investigate the number of patients there. Problems occur when the doctor asserts that not everyone who goes into his clinic is sick but that there are visitors, guests and sick relatives, while the tax official insists that everyone who goes into the clinic is sick. Keeping a daily record, for a doctor, is a harsh, difficult process. It takes time and needs an accountatant. There remains the problem of exorbitant appraisals, which the doctor rejects and because of which he gets into conflicts and disputes with the department.

AL-MUSAWWAR: So what is the solution?

Dr Hamdi al-Sayyid: We have demanded that a fixed tax be spelled out which doctors will pay each year and will increase 10 or 20 percent a year, so that the doctor will know what he will be held accountable for each year. This sum will be broken down by months of the year.

The department rejected this request. It is hard on people who send it papers, but it does not go looking for evaders, because it is difficult for tax officials to look for evaders and easy for them to harrass people who present them official papers. As an example, there are 35,000 contractors in Egypt and only 3,000 pay taxes.

Dr Salah Hamid's policy in this area is good; it is a good start in holding people who evade taxes to account. That does not prevent us from talking about the Tax Department's problems in terms of the volume of the unremitting labor, the lack of ledgers and the accounting system. We go to the department and they ask us to look for our own ledgers on the shelves.

We have said that we are in favor of being accountable to the law on wealth, but the authority does not agree. We demand that a system be set forth that will put professional people at ease. One should bear in mind that private hospitals are subject to commercial taxes, not professional taxes, but it has a different system, with stiff accountability.

AL-MUSAWWAR: What are your observations about medical education in Egypt, especially the opening of new medical faculties? Why do most graduates go off to Europe and the Arab countries — isn't there any feeling of commitment to the nation?

Dr Hamdi al-Sayyid: We have started to view the problem of medical education as if it were a chronic disease for which there is no remedy. It appears that no one is responsible for the problem. However, I can say, first, the composition of the profession has changed as a result of the fact that 4,000 graduate a year. Society views the medical profession as a profitable one with a big income that requires little effort and offers high social standing. This change will continue in coming years. In the next 5 years, 40,000 doctors will graduate, representing 50 percent of the number of doctors now present in Egypt, including doctors who have gone abroad, emigrated or died.

Today, before coming here, I read an article by my colleague Ahmad Zaki Karim, who is a doctor in the armed forces. He wrote his memoirs and reminiscences of the days of our studies in the university, the care we received, the firm relationship we had with professors, and the invitations they gave us to their homes for dinner. There were only 60 students in a graduating class.

AL-MUSAWWAR: What happened then?

Dr Hamdi al-Sayyid: After 1961, it happened that a storm of students entered the medical faculties; a single graduating class would have 10,000 students, everyone relying on his own wits. Education became the responsibility of the indivudual, and receptivity to private studies intensified, courses would run as high as 700 pounds, and students who wanted to excel took more than one course, which would cost them about 3,000 pounds a year. This is the only way to study under the current circumstances. Students who rely on lectures alone will get nothing out of it at all. The medical profession is a profession of competition, since every student wants to excel.

AL-MUSAWWAR: This is as far as education goes. What about training?

Dr Hamdi al-Sayyid: There are no opportunities to train students. The students must acquire training in the faculty; after the graduation, there is training for the

master's degree and intensified training, which is known as the doctorate. More than that, the profession requires constant training, even after the doctorate, or the doctor's level will be badly affected — developments are taking place in this field every day.

We have been teaching medicine in Egypt in the same way for 50 years, and it is now necessary to devote ourselves to local medical education. Our problems are very different from those of medicine in America and Britain.

We have malnutrition, different kinds of fever, poverty and so forth.

AL-MUSAWWAR: Have we started to fight on more than one front?

Dr Hamdi al-Sayyid: Every year we see a plan to build a new faculty of medicine. How so?

What happens is that people find a good hospital and say "We will erect a faculty herein. Where are the theoretical studies?"

We are told, "In the laboratory, in the adjacent secondary school, or in the garage. We will soon erect a faculty building and the cornerstone will be laid." Then the construction does not take place, in view of budget conditions, shortages in allocations and the wars the country has waged. The situation has gone on like this for 30 or 40 years. We ask what all this talk is about and we are told "Directives; higher government policy." Once I insisted on learning what the source of these directives was, I carried out an investigation myself and I found no source for these so-called directives. It was just a matter of an innate fear of officials. We prepared studies and sought the aid of the American University, but all these studies are ignored and no one pays attention to them.

We succeeded in reducing the number of students and objected to the case of people coming from abroad, since their level was low and they relied on intercession and bribery to pass, corrupting education in Egypt and abusing our education, since students coming from abroad go back to their countries and say "I got the certificate through the bribes I paid Egyptian professors."

Now only 5 percent of the students coming from abroad go to medical faculties. They obtain grades similar to those of Egyptian students because on some occasions we used to accept people who had had to repeat courses in their own countries so they could receive bachelor's degrees in medicine from us.

Second, we have succeeded in limiting the number of new faculties. Although the establishment of a medical faculty in a governorate will greatly help improve medical service, as has happened in al-Mansurah, Tanta, al-Zaqaziq and Asyut as a result of the availability of professors and scientific research, in spite of that a modicum of financial resources must be present if we are to succeed in establishing a new university. The experience with the establishment of the Suez Canal University has been a success, since we gave our agreement to the opening of the university only after every resource was made available and after careful supervision on the union's part which lasted 5 whole years. Nonetheless, we limited the number of students the university accepted to just 50; they enrolled in the faculty of medicine at the Suez Canal [University].

We are following up on this pioneering experiment in the field of local treatment, mixing theoretical studies with a practical expertise and going down into the village starting the first day of class.

It will take some time to establish medical faculties in the Governorates of Sawhaj and al-Minufiyah if we are to be able to come up with all the requisite facilities and material resources.

We are working to reduce the number of students in the university; we have 39,000 students in medical faculties in Egypt, 8,000 of them in Cairo University and another 8,000 at 'Ayn Shams.

This year, for the first time, we are seeking to merge practical training with theoretical studies and instruction in behavior, environment and pollution. Students will study these subjects for a period of 5 whole years.

We have also sought to prescribe training and not content ourselves with theoretical study at the master's level — rather, we will introduce studies and practical training as well.

As regards behavior, that is learned not through education but through good example. How can a student learn humane behavior when he has to examine a patient at the head of a line of a thousand patients in a few minutes and the orderly sees him striking the patient and perhaps giving him a slap, then finds that his boss is passing the patients on every few minutes — how can that be a good example?

I remember that when I was in Britain, our professor, who was a big lord, would not address a patient without calling him sir, that is, "sidi" — "Would you allow this student to examine you, sir?" Then he would show him the virture in doing that and would himself supervise the warming [sic] of the patient. In Egypt, however, the patient consists of a case, a number, just a number; there is no humane behavior in Egyptian hospitals.

The medical profession, like carpentry for instance, must depend on "master and apprentice." The professor must have one, two or three pupils at the most whom he will instruct and train. Now, however, no one knows what his pupils look like or of course their names; when a doctor comes to me and tells me, "I was your pupil," I say, "Heaven's name, son, how can I remember?"

I would like to say that if the government did not spend half its material resources on training and education there would be no development in Egypt. Development consists of man and resources, then the exploitation of resources. All our problems come from a lack of adequately trained people.

AL-MUSAWWAR: The phenomenon that inspires amazement in the medical faculty is that of the children of professors; it is not reasonable that all the children of professors should by coincidance be exceptional!

Dr Hamdi al-Sayyid: The reason for this phenomenon is:

The extreme difficulty the medical student faces today; competition between the professor's son and the ordinary student is unequal. At the outset I can say that the

professor's children are not backward, but entered the faculty after passing a general examination, the "general secondary," and entered the competition with their colleagues starting at the same point.

As regards the exceptions, those just come to 5 percent; the children of professors in all fields of specialization and other branches such as law, engineering, commerce and so forth form part of these; the ratio of children of professors is just 1 percent; the rest get in through their own efforts, which are great.

However, we do find that professors introduce their children to professors and courses and enable them to mix with their professors; I send my daughter to a fellow professor to help her in matters in his specialization in which she has difficulty, for example.

It is also wrong for the grade to be divided into three sections, and for the grade on oral examinations to make up two-thirds of the final examination grade. This is wrong, as is the courtesy doctors provide for their colleagues. We are human beings and we find that the sons of professors are not afraid of oral examinations because they sit down with the professors and hold discussions with them freely, while the ordinary student comes into an examination confused.

Therefore we have started the system of multiple-choice written examinations. Grading is done by computer; 'Ayn Shams University has actually started this system.

We will work to have oral grades in all faculties brought down to the lowest level possible.

AL-MUSAWWAR: Isn't there some kind of coordination among university professors?

Dr Hamdi al-Sayyid: Absolutely not. The ones who have the right to choose are the top 10 only, and among the top 10 only one is a child of a professor. The bachelors' degree continues [to determine] the choice throughout the life of the doctor, even when he receives a doctorate. That is absolutely unfair; a single year cannot determine a man's whole destiny.

AL-MUSAWWAR: There is an argument in favor of Arabizing medical education in Egypt. This would require at least 6 years of constant intense effort. What is your opinion?

Dr Hamdi al-Sayyid: Here we are getting into an issue of educational philosophy. Which is better — for me to be taught in my own language or a foreign language? What scholars of education agree upon is that when people are taught in their original language they easily understand and absorb what they learn, but if they are taught in a foreign language they translate what they are told in their minds, then proceed to understand it, and do the same thing before they answer - translating, then answering - which is a strenuous mental process.

In every country in the world, including Finland, they use their own national language. The Arabic language contains many words and synonyms and yet we study in a foreign language. In the 17th century, doctors who did not know Arabic were considered failures. Arabs translated Greek and Persian scientific works and improved on them; is there no one in Egypt who can do the work of Arabization?

In the course work we also find a very strange sort of pidgin Arabic. The lectures are given in English and then are repeated in Arabic. A student who misses a word will understand nothing from the lecture.

In examinations, we can find no less than 100 errors in English spelling on a page, and we let that by.

We are now preparing for master's degree studies for general practitioners for the first time. We sought the assistance of a group of British experts in readying 150 students for this course. The British asked us, "How could you be so negligent as to give doctors courses in English? Won't the doctors be talking to the patients in Arabic? This is very strange!"

Similarly, although I went to Britain, lived there for 5 years and speak English like my own language, there are nonetheless some words the patient in Egypt uses for which there are no corresponding words in English, and we have to write them down in Arabic. An example of that is the word "cough" — the patient says "I am coughing," or the patient says "my chest is urinating."

AL-MUSAWWAR: How can we keep up with new things in the world of medicine?

Dr Hamdi al-Sayyid: The answer to that is that strong English language courses must be prepared, equipped with language laboratories, each student should learn a suitable language, and we should not confine ourselves to English studies — rather, the students should learn English, French, German and Russian, we should open up to various medical schools, and success in language should be a condition for obtaining a bachelor's degree.

AL-MUSAWWAR: I believe that we have talked a great deal about the city. I, for example, my village is al-Dahriyah, Itay al-Barud District, al-Buhayrah Governorate; it has a population of 35,000 and half a doctor, in the sense that he works there half the days of the week, and the other half in another village. My village is in al-Buhayrah.

Dr Hamdi al-Sayyid: That is very odd.

AL-MUSAWWAR: There is no first aid vehicle or operating room.

Dr Hamdi al-Sayyid: You are talking about a rural unit.

AL-MUSAWWAR: This is a collective unit. The doctor just works there 3 days.

Dr Hamdi al-Sayyid: This is a very serious shortcoming, because the system that exists in the rural areas consists of two systems. There are the rural units, which serve from 3,000 to 10,000 citizens; these number 2,500 in the rural areas. The number of these units is supposed to increase and the number of people the unit serves is supposed to decrease to no more than 5,000. The rural units are supposed to offer services which are known as basic medical treatment, such as the treatment of endemic diseases, emergency services and preventive services; a doctor is supposed to be attached to them - now two doctors - and some units have a dentist, a health aide, a wet nurse or midwife, a female nurse and a laboratory assistant. This mass of people is supposed to be furnished with what is called basic medical care, which means, first

of all, contact between the citizen and the profession. If the citizen suffers a minor ailment, he goes to the unit. Likewise, it is the doctor's field of specialization to give mother and child care and examine school students, which is known as school medicine. The doctor operates a family planning unit so that he can engage in providing guidance for pregnant women, distribute interuterine devices and so forth, and he treats endemic diseases. Do these units do their job as they should? The answer is no, because of the great shortcomings. One of the causes of these shortcomings is the fact that the doctors there are not well trained and the responsibilities they bear are very grave. The doctors graduate 3 months beforehand, train for a period of 2 months, then go to work in these units. Naturally they are not effective enough. More importantly, the doctor is the head of a team, and when he goes he finds a grizzled old orderly and also a health aide and a local medicine man, and they play games with him from the moment he first gets to the unit. The doctor who does not have expertise or experience is surprised to find savages; either he joins forces with them and takes money from the people who frequent the unit, or complaints rain down against him from his first day until he is transferred. This is an extremely serious issue. The doctor is requested to do compulsory service in the health units for a year. Many doctors fail in this experience; a few doctors succeed and can lead, because the doctor can interact with the chief of the village or the village head. We hope that in the future doctors who have master's degrees in general practice will go to these units and will have doctors with them who will train with them and be under their supervision: these doctors with master's degrees should have from 3 to 4 years' experience and should be able to deal with problems and be competent leaders. This is one of the problems of medicine, because students in medical faculties do not study management science. One should bear in mind that a large part of the doctor's job is management, to enable the doctor to deal with the whole gang, which consists of an orderly, a wet-nurse, a health aide and so forth, because when a graduate doctor appears before this group they start to learn about him and if he joins forces with them then he is in it and if he does not, sneaky complaints will rain down on him until he runs away. I have nothing that is more voluminous than complaints about these doctors. In addition, we have asked that these doctors be given permission to open clinics in the afternoon so we can tie them to the village. First, that will free them from putting their hands in patients' pockets, because they will get something from examining patients in their clinics in the afternoon. The extent of their control over the people working in the clinic will increase when they are given bonuses and incentives from the unit income related to the clinic, and also, by tying them to the village, the village will get to like them, they will reside there, they will not leave it, and we will go back to something resembling the era of the health inspector who would refuse to leave the village once he had established many ties with the people in it.

AL-MUSAWWAR: What exactly is the case regarding the rural areas?

Dr Hamdi: The case is that these doctors need good training and at the same time need incentives that will tie them to the place so that they can do their job thoroughly.

The second system is that of health groups. When they were operating, there were hospitals; some of these had 20 beds. The Ministry of Health gradually started to expand these hospitals, because they provided idle capacity — there were 8,000 idle beds that were not occupied, and we needed these beds. Then the Ministry of Health started to establish what are called village hospitals, causing some specialists who work in the central hospital to want to perform operations, deliver babies

and train doctors. This experiment did not succeed totally, because an inefficient amount of incentives were provided: without incentives you cannot produce results, especially in the field of medicine. We must entice doctors to work and convince them that their future is in the rural areas. I told them this, that their future was in the rural areas. If a doctor stays in the village, makes a presence for himself, makes a name for himself, and creates a relationship with the citizens for himself, especially now that many villages have started to be located on main roads, and have electricity, water and schools, for the first time, after 2 or 3 years, some of them will remain in the rural areas, because, after the first year is up, we will provide these doctors with a choice — either to remain in the rural areas or to receive specialized training in the hospitals. Today, more than half of the doctors prefer to remain in the village, especially now that the doctors manage to get an income for themselves. The doctors have some marginal income, such as house calls, receiving 30 piasters per visit, and they get a family planning bonus of 10 pounds. If they open clinics for themselves, especially if they are properly trained, the rural areas will be transformed completely, to the point where each village will have a doctor connected to it and he will help the peasants improve their standard. He will be able to work in health education and be effective in family planning matters. I hope that the day will come when a doctor will go give the Friday prayer in the village mosque, because he will be able to introduce notions of health and cleanliness as a part of the religious instruction. However, the doctor does not have the appetite for this; he is disgusted and he does not know how to act. If I could tie him to this place I would find young persons who could live in the villages and do good service.

I can say that the rural unit system is the most splendid system in the world and is without equal in the world. It is a network spread out throughout Egypt and the government can benefit from this network for many things. When pilgrims afflicted with cholera return to Egypt, each of them is under control, because there is no pilgrim that does not have a rural unit alongside him that can monitor him. Why was infantile paralysis inoculation a success? Because these centers were working properly through incentives under a national campaign. This is a public cause that also stirs up such great enthusiasm and nationalism in the people that they start to work well.

AL-MUSAWWAR: What is your opinion about the birth control issue?

Dr Hamdi al-Sayyid: I have a specific viewpoint on this problem, because it does great damage to talk about it as if it were birth control - that immediately stirs up diverse contractictory reactions, among them what Ahmad Baha'-al-Din wrote, to the effect that population is a blessing, not a vengeance; it starts to provoke religious sentiments, claims that you do not give sustenance to anyone or that sustenance is guaranteed, and a lot of talk. I say that Egypt's problem must be discussed in the framework of what is called the population problem in Egypt. When we define that, we will be speaking in a more comprehensive manner and will not be dealing with a small particular point, which is just reducing the size of the family. Without a doubt, the people who claim that we are issuing a law and punishing people who produce a fourth child and that that is inhumanitarian and unrealistic, because it is the citizen's right and the right of people all over the world today, the citizen's right to have the size family he considers appropriate — this is one of the rights of the citizen, not one of the rights of the state. In Communist countries like China that have imposed the right by law and state "I will cut off the head of anyone who has more than two children." That sort of talk is illogical; my job, as the government,

is to provide every citizen with information and means that will enable him to limit his family in the manner he sees fit. The second problem in dealing with the issue of family planning is that we are trying to encourage people from the angle of national obligation, as if we are placing the responsibility for Egypt on the shoulder of every citizen. The answer is, "All right, what's it got to do with me, as long as my children earn money and don't cost me anything?" Children in the Egyptian village go to the fields, the day wage for agricultural labor is 3 pounds a day, and we cannot preach to the Egyptian citizen from this angle. Ultimately we say that the process of procreation differs with each person and, if we cannot create alternatives, a method or means for changing this conduct, people will not proceed seriously with the family planning process.

We ask, is there a population question in Egypt? Of course there is. Part of the population in Egypt is living below the sufficiency level. Part of the population does not get food. Part of the population does not get enough calories. Part of the population does not get enough protein to build up tissues. Part of the population is illiterate, unemployed, cannot find housing, cannot find opportunities for work or education. Congestion is everywhere. We have become crowded together in a narrow strip. In the Bab al-Sha'riyah and Rawd al-Faraj sections, the population density amounts to 105,000 per [square] kilometer, which is the highest density in the world. Nobody can breathe in Cairo. Anyone who says that there is no problem of crowding, congestion or population density is wrong. There is a problem of poor population characteristics in Egypt; people are quarrelsome and do not enjoy life. That is, the population that is present today is not respected; the population to come will not receive its rights; human rights are not available to it in terms of education, health, or national income. If we agree on this point and wonder if there is a population problem in Egypt, the answer to that is that there is a very enormous population problem in Egypt; it is the prime question. The second question is development — what are the elements of development? Its elements are resources, population, and the means for using resources in terms of technology and management. This element was not taken into account when Malthus defined the population problem and said that the world was faced with a shortage of resources and that consequently a famine would occur. He did not take into account the advent of technology, which managed to increase productivity per feddan and land yield and use computers and insecticides.

There are countries that have a balance between resources and people, and their resources are developed by the very people who are there; they use technology and progress. An example of that is a country like Japan — its resources are man, which it uses through technology. Then there are countries that have resources and are short on people, like the Arab Gulf area.

Germany employed 6 million workers from Turkey and Yugoslavia; today, there is unemployment there - that is, there are resources but no people. People are not enough. There are countries that have few resources and many people, and there is a surplus in them. Does Egypt's problem with development lie in the fact that it does not have enough people? I say that Egypt has many people but that their specifications are low. There are more people than there should be, and they can develop more than 10 times the resources they have; they could have developed the resources of the Gulf and Saudi Arabia, but their specifications are low, in the sense that they are not sufficiently educated. Illiteracy is great, their health is not good, there is no housing, they are not well trained, and they are poorly distributed as labor, with

surplus labor here and a shortage there. If Egypt produces another 10 million people, will the problem of carpenters and mechanics in Egypt be solved? I can solve the problem of mechanics in Egypt in 6 months by redistributing the labor. I have enough people for my resources, but the specifications of the people are low and one must develop these specifications. I ask people who say that people are a resource, where is the return on this resource? People producing a third of what they eat? Our entire national output is inadequate for half of what we import. Let us eat; we eat in debt — that is, people are living in a state of dependence. That is, people do not produce, and then someone comes up and says, "We want people." Fine, let me make use of what exists, redistribute it, organize it and guide it. As far as women go, are we benefitting from the human workforce that consists of women? What percentage or women are working? This is idle capacity, and therefore the issue of education for mothers and education for women is important. If we rise above the illiteracy rate, which comes to 80 percent among women, the situation will change. The first thing mothers and educated women who want to improve their incomes do is protect their health and their condition and plan their [families]; much of the motivation for planning comes not from men but from women. Ignorant women are always resigned to reproducing like rabbits. They have no opinions or ideas of their own, and therefore the issue of illiteracy among women is a basic one: How can we solve this problem? People, the solution to this problem is through comprehensive development; that is the absolutely truth. When I am speaking about comprehensive development, the first development is with mankind, because 50 percent of the development must be oriented toward man.

AL-MUSAWWAR: Is dispensing drugs without prescription unsuitable to the nature of Egyptian society?

Dr Hamdi al-Sayyid: When the issue of dispensing drugs without prescription was raised, much debate swirled about it. It was said that this was a method where every citizen was supposed to go to the doctor, even for simple ailments. We recommended that we should remove the minor drugs that any citizen can ask for from the prescription list, because their side effects are minor, but the other drugs should be dispensed only by prescription and, lest we be accused of encouraging people to go to doctors, we said that doctors practicing in government hospitals should be permitted to write out prescriptions that would be dispensed outside the hospital, because doctors in government hospitals are prohibited from writing out prescriptions. We demanded that any patient to whom something happens should go to the hospital or reception area and a doctor should examine him and write a prescription out for him that would be dispensed outside but would be stamped by the hospital. That plan met with no enthusiasm.

AL-MUSAWWAR: We have really burdened Dr Hamdi al-Sayyid down. The fact is that we have not been talking to a doctor, we have not been talking to the head of the Doctors' Union — rather, we have indeed been talking to a man who is informed about Egyptian society, who knows all its side symptoms - a man who looks upon the health problem from the standpoint of Egyptian man as a whole. We thank him for this valuable symposium and believe that this has really been one of the most fruitful of the symposia here because it has filled our minds with many facts, has placed many figures before our eyes and has put our fingers on the truth of problems. We thank the doctor for accepting and honoring us, and we promise him that we will be completely faithful in publishing this and will weigh every word that was said in this symposium.

Participating in the Symposium

Makram Muhammad Ahmad, 'Abd-al-Nur Khalil, Yusuf Fikri, Muhyi-al-Din Fikri, Layla Marzush and Yusuf al-Qa'id.

Attending the symposium were Dr 'Abd-al-Rahman Nur-al-Din, editor in chief of TABIBAK AL-KHASS, Dr Mustafa Hajjaj, 'Atif Faraj and Nabil Rashwan.

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CSO: 5400/5012

BRIEFS

GASTROENTERITIS OUTBREAK--St. George's, Grenada, Saturday (CANA)--GRENADA has been hit by an outbreak of gastro enteritis, but the health authorities have assured the public that there is no need to panic. Speaking in St. George's, Secretary (Junior Minister) for Health Dr. Bernard Gittens, said the outbreak was mainly in areas where sanitary practices were substandard, and he appealed for greater efforts to improve environmental sanitation. "There have been no cases reported in areas where refuse is properly disposed of, such as in the hotel development areas," he said, "and clean up efforts in affected areas are already showing satisfactory results." [Bridgetown SUNDAY ADVOCATE-NEWS in English 2 May 82 p 3]

CSO: 5400/7549

MEDICAL RESEARCH COUNCIL ISSUES ANNUAL REPORT

Bombay THE TIMES OF INDIA in English 26 Apr 82 p 19

[Text] New Delhi, April 25 (UNI)—Communicable diseases still ranks as major public health hazards in India despite the efforts to control them, according to the annual report (1980-81) of the Indian Council of Medical Research (ICMR).

The report says, among these, tuberculosis, leprosy, malaria, filariasis, cholera as well as viral diseases have received special attention of the council. Seven permanent institutes of the council have undertaken research on these diseases.

The council's National Institute of Cholera and Enteric Diseases, Calcutta, has stepped up its efforts to popularise the use of oral rehydration therapy in various parts of the country by organising seminars and workshops in which local health authorities and public health personnel have actively participated, the report says.

In the field of tuberculosis, the council's tuberculosis research centre in Madras continued its studies on domiciliary therapy with the main aim of reducing the cost as well as duration of the treatment, without loss of efficacy.

The vector control search centre in Pondicherry has extended its activities to field projects involving the community by initiating an integrated research-cum-action-oriented project on the control of vectors of filariasis in the country, the report says.

Leprosy Patients

The council's Central Jalma Institute of Leprosy (CJIL) in Agra is conducting studies on the pathogenesis, transmission, immunology and chemotherapy of leprosy, as also rehabilitation of leprosy patients. In view of the detection that several strains of the lepra bacilla are proving resistant to Dapsone--the sheet anchor against leprosy, the CJIL is attempting to evolve treatment schedules involving several drug combinations.

The National Institute of Virology (NIV) in Pune, which is a recognised centre for arbovirus research, has extended its studies to several other viral

diseases like influenza and viral hepatitis. During the year (1980-81), a viral encephalopathy research unit has been put into operation to function as a central serological laboratory. The NIV has played an important role in surveying and monitoring outbreaks of viral diseases such as Japanese encephalitis, Kyasanur forest disease and dengue in various parts of the country, according to report.

The report says that unless the "present disturbing rate of population growth is checked effectively, none of the targets set for self-reliance by India in any aspect of development can be achieved."

CSO: 5400/7068

PRESS REPORTS OUTBREAK OF MYSTERY DISEASE

Suspected Malaria

Calcutta THE STATESMAN in English 27 Apr 82 p 3

[Text]

A THREE-member team of doctors from the School of Tropical Medicine, Calcutta, will fly to Jalpaiguri on Tuesday to diagnose cases and suggest measures to combat the mysterious killer fever, which had broken out at Banarhat tea estate in the Dooars and had claimed a number of lives.

Mr Jatin Chakraborty, acting Health Minister, told reporters in Calcutta on Monday that the fever was suspected to be a "virulent form of malaria". He said both the Chief Medical Officer of the district and the Regional Director of Health in the Union Government had visited the affected areas, but failed to diagnose the disease.

The Minister said that orders had been given to spray mosquito oil and similar chemicals in the affected areas. Experts from the malaria department had also been asked to go there.

Mr Chakraborty said that according to latest reports, eight persons had so far died of the killer fever at Shalbari gram panchayat at Dhupguri block in Jalpaiguri.

UNI adds: A disease, which has not yet been diagnosed, has claimed six lives in Ranauli in Sikar district during the past few days, according to reports reaching Jaipur State headquarters.

Dr B. M. Sharma, Director of Medical and Health Services, said that a person afflicted by the disease first complains of fever, stomach cramps and diarrhoea. This is followed by acute renal failure. The person dies in four or five days.

Dr Sharma said five people from Shishugram village had been admitted to a hospital in Jaipur in serious condition and even dialysis had not proved useful.

Unofficial reports, however, put the number of deaths due to the disease in the village at 20.

Disease Reported Spreading

Calcutta THE STATESMAN in English 4 May 82 p 12

[Text]

BHOPAL, May 3.—Five new cold storages are to be set up in the cooperative sector in the State with World Bank assistance.

Of these three will be of 4,000 tons capacity each and the remaining two will have the storage capacity of 2,000 tons each. With the addition of these five cold storages, a further storage capacity of 16,000 metric tons will be created.

The cost of these will be about Rs 2.66 crores in which the State Government will have 30% share.

CSO: 5400/7070

BRIEFS

LEPROSY IN MARATHWADA REGION--Aurangabad, April 26 (UNI)--The backward Marathwada region of Maharashtra has a higher percentage of leprosy than any other part of the state, according to a study conducted at a camp held in Dharmabad in the region's Nanded district. Dr Ishwarprasad Gilda of the J.J. Hospital in Bombay, who supervised the study, told UNI here he had found the number of diseased persons ranged from eight to 12 per thousand in different parts of Marathwada, which has no proper treatment facilities for the disease, "despite being a hyper-endemic area." He said a large number of leprosy cases did not cross even the diagnostic stage due to the backwardness of the people of the region, and the high poverty and illiteracy rates among them. Even the majority of doctors had no proper knowledge of the treatment of the disease, he felt. Dr Gilda said of the 3,000 persons examined at the camp, 300 were found to suffer from general skin diseases and 110 were victims of leprosy. Forty per cent of these cases were infectious and posed a serious "public health hazard." He said that even though the World Health Organisation (WHO) had declared the medicine "rifampicin" as ideal for treatment of leprosy, the drug--to be administered to patients every day for at least six weeks--was not available in Marathwada. As a result, leprosy cases in the region were on the increase. [Text] [Bombay THE TIMES OF INDIA in English 27 Apr 82 p 5]

CSO: 5400/7069

UNIDENTIFIED DISEASE CLAIMS TWO LIVES

Kuala Lumpur NEW STRAITS TIMES in English 15 Mar 82 p 7

[Text]

IPOH, Sun. — A disease which recently struck the labour quarters of the Rahman Hydraulic Tin Bhd in Tanah Hitam near Kilan Intan, has been described as "a phenomenon peculiar only to this particular place".

Sources said this is the first time the area has experienced the disease, which is suspected to be waterborne.

The disease has reportedly claimed the lives of two infants, and 60 people have been affected.

Vomiting

It causes body itch and pain in the chest. The victim's eyes also become red and their faces swollen.

In several cases, victims vomit and purge.

The sources also said the disease was unheard of before.

The mine's labour quarters get their water supply from a river near the mine.

It is understood that samples of the water will be sent to the Chemistry Department soon for analysis.

CSO: 5400/8420

RUBELLA IMMUNIZATION PROGRAM BEING CONSIDERED

Kuala Lumpur NEW STRAITS TIMES in English 5 May 82 p 13

[Text]

KUALA LUMPUR, Tues. — The Ministry of Health may introduce a German measles (rubella) immunisation programme for women should the spread of this disease worsen.

Its Director of Health, Datuk Dr Ezaddin Mohamad said it was too early to tell if such a programme was necessary, as only a superficial study of the extent of the disease infecting pregnant women had been done.

Rubella, according to one Institute for Medical Research survey, is responsible for congenital defects in 20 to 30 per cent of children born.

Dr Ezaddin said the Ministry was concentrating on the 'classical' or ordinary measles immunisation programme for children between nine months and two years.

This programme which began as a pilot project last year will be implemented in June.

An IMR researcher, Dr Dora Tan who is with the virology unit said a TORCHES (which stands for toxoplasmosis, rubella, CMV infection, herpes simplex and syphilis) survey done last year, showed that the rubella antibody rate in children with congenital defects was 71.4 per cent compared to 5.8 per cent in normal children.

German measles antibodies were also alarmingly high in children with congenital heart defects (50 per cent), deafness (81.3 per cent), cataracts (33.3 per cent) and liver enlargement with or without jaundice (20 per cent). About 2,000 children were tested in the survey.

Dr Tan in a paper presented at a seminar on viral diseases in the region, held in Canberra in February, said that as acquired rubella was rarely seen in children under five years of age, it could be assumed that the child received the anti-bodies from the mother as a result of intra-uterine infection during pregnancy.

She concluded in her paper that in Malaysia, German measles was the primary cause of congenital heart disease, cataracts, deafness and liver abnormalities.

Disastrous

Dr Tan said it was not the norm, that defects arising out of rubella infection became apparent in the first few months of a child's life.

"More often than not you do not see the defects at birth," she said.

"Delayed manifestations of rubella are not uncommon and may even make an entry when the child reaches adolescence," she said.

In expectant mothers, the result could be disastrous for their unborn babies.

However, while there have been epidemics of the disease in certain European countries and Australia, Malaysia has so far been spared.

CSO: 5400/8420

CHOLERA IN SARAWAK, HEPATITIS IN SABAH

Kuala Belait BORNEO BULLETIN in English 24 Apr 82 p 4

[Text]

KUCHING. — Four cases of cholera have been confirmed this month in Sarawak's Sixth Division.

All cases were from the Matu-Daro District and were treated at Sarikei Hospital.

Two of the victims, a two-month-old baby girl and a four-year-old girl from Kampong Nangar were from the Daro area.

The other two came from Matu. One was a 21-year-old man from Kampung Bawang and the other a woman, 36, from Kampung Seka'an Besar.

So far this year five cholera cases have been reported in Sarawak all from the Matu-Daro District.

Doctors have warned the public not to visit the affected kampungs and to keep clear of Sarikei Hospital to prevent the disease spreading.

They also advised people to take extra care in every day life and drink only boiled water and eat freshly cooked food.

Meanwhile, in Sabah's capital Kota Kinabalu the number of cases of infectious hepatitis continues to drop, according to Medical Services Director Dr Mechiel K. C. Chan.

He said that for the week ending April 11 only 11 cases of the disease were detected by doctors at the general hospital here.

This is the lowest number since the hepatitis epidemic in February when up to 80 cases were being reported each week.

Dr Chan said Medical Department officers are still checking restaurants, coffee shops and food kiosks in Kota Kinabalu, Sembulan, Tanjung Aru and Penampang and action is being taken against premises not complying with health regulations.

Two weeks ago 19 premises were inspected and food samples from eight were found to be faecally contaminated.

Two coffee shops have been banned from serving ice indefinitely after an inspection showed their ice contaminated.

The two shops were among 10 ordered to stop selling ice for a a week on March 26.

The indefinite ban was imposed when inspectors returned after a week and the ice in two of the shops was still contaminated and unfit for human consumption.

It is believed the contamination does not come from the water used to make the ice but from the dirty hands of workers handling the ice.

Health inspectors have warned restaurant owners to keep their premises clean at all times and said checks on all eating places in the state will continue.

CSO: 5400/8420

BRIEFS

CHOLERA IN SARAWAK--Another two cases of cholera and four carriers have been reported in the last 3 days, all from the Matu District in the Sixth Division of Sarawak. The latest figures bring the number of confirmed cases in the state this year to 20 and carriers to 25. The cases are two babies from Daro, while the four carriers are from Matu. [Text] [Kuala Lumpur Domestic Service in English 1130 GMT 14 May 82 BK]

CSO: 5400/5994

BRIEFS

MALARIA CASES--For the year ending 31 March, reported cases of malaria totalled 240 (133 male, 107 female), a marked increase over the previous year's total of 185 (107 male, 78 female). Seventy-three cases were reported in March. Most cases occurred in Flacq (Brisee-Verdiere, Lallmatie, and Bon-Accueil). [Excerpts] [Port Louis L'EXPRESS in French 27 Apr 82 p 7]

CSO: 5400/5993

FEWER PACIFIC ISLANDERS IN AUCKLAND HAVE TUBERCULOSIS

Auckland THE NEW ZEALAND HERALD in English 20 Apr 82 p 11

[Text]

Fewer Pacific Islanders in Auckland are developing tuberculosis as a result of the Health Department's campaign against the disease.

In 1975, of the 65 children in Auckland with tuberculosis, 46 were Pacific Islanders.

Last year only six of the 12 notified cases in Auckland children were Pacific Islanders, says the medical officer of health for Auckland, Dr John Stephenson.

"The racial distribution of the disease among adults is also changing, and the earlier predominance of Pacific Islanders with tuberculosis is no longer seen," he says.

"This different pattern of disease indicates our detection and prevention programmes aimed at 'high risk' groups have been effective."

Maori and Pacific Islands people form these "at-risk" groups because of what appears to be an increased susceptibility to tuberculosis.

"In 1976 four programmes were aimed at those at risk, including immunisation of newly born babies at National Women's Hospital.

"Of the 2462 vaccinations performed in 1981, 1233 were for Pacific Islands babies and 977 for Maoris," says Dr Stephenson.

"By agreement with Western Samoa, Tonga, Fiji and the Cook Islands, all visitors staying in New Zealand for over two months received a chest x-ray.

"Because the disease becomes manifest after some months in this country, long-stay visitors and immigrants were offered an x-ray at six and 12 months after entry."

The two mass miniature radiography caravans in Auckland now concentrate on offering x-rays to at-risk groups.

In 1981 the programme yielded six cases of tuberculosis from 32,109 x-rays.

All five tuberculosis deaths in Auckland last year were of elderly Europeans, Dr Stephenson says.

CSO: 5400/9083

MEASLES OUTBREAK IN KANO CLAIMS SIX LIVES

Kaduna NEW NIGERIAN in English 26 Apr 82 p 16

[Article by Abdulhamid Babatunde]

[Text]

SIX children have died as a result of measles outbreak in Kano, and at least 300 others have also been admitted at the infections diseases hospital in Kano since the outbreak about a month ago.

As a result of the outbreak, the hospital has been congested by victims of the disease and their parents, many of whom are receiving treatment in makeshift sheds in the hospital premises.

In an interview in Kano on Monday, the Chief Medical Officer in the Kano State Health Services Management Board, Dr. M.A. Kura confirmed the deaths and those on admission.

Commenting on the congestion at the infections diseases hospital in Kano, the chief medical officer pointed out that the hospital was the only one serving the state and even some neighbouring states.

He added that the congestion was mainly as a result of measles victims because the disease was normally at its peak during the hot season before rains.

He said the disease mostly affects children of tender age who don't have enough immunity to build up against it.

Dr. M.A. Kura could not rule out the possibility of victims dying outside the hospital.

He remarked that the ideal thing was for infants to be vaccinated shortly after birth but lamented that only 40 per cent of births were in hospitals.

He said measles could be wiped out if every child could get vaccinated and advised parents to take their chilren for vaccination during mass vaccination campaigns.

CSO: 5400/5992

AIM OF ENDING LEPROSY PROJECTED FOR 2000

Lahore VIEWPOINT in English 6 May 82 p 32

[Text] THIS is the aim of the Marie Adelaide Leprosy Centre and the National Leprosy Board. The Centre has been the pioneer group in Pakistan's battle against the disease. It had an incredibly humble beginning, a dispensary in Karachi made entirely of wooden packing-cases bought from a patient. This was in January 1956. The first leprosy sufferers found by the pioneers lived with their families in a beggars' colony, amidst overflowing gutters, vermin, garbage—they lived as outcasts. The Archbishop of Karachi had called upon the Sisters of his diocese to come to their aid. Later came donations from international organizations, helping to lift the work from the gutters and packing-cases into its present buildings, and its extended programme.

It was but as recently as 1967 that the expediency of a Greater Karachi Leprosy Control Programme was recognized. Centres spread out over Karachi's crowded areas, and then attention was drawn to areas of infection in other parts of the country. A Leprosy Technicians' Course came under recognition by the Punjab and Sind Medical Faculties. Throughout Pakistan 19,000 patients have been registered, but the estimated figure of at least 35,000 sufferers spread out over Pakistan adds a new urgency to the programme for its control, and the cure of sufferers.

Not widespread

Fortunately, Pakistan is a low incidence area, unlike India, Thailand, Burma and Bangladesh. Within Pakistan, Sind, but for a few cases, is more or less free, the Punjab, too, apart from the major towns. But the Northen areas, according to the Centre, may be considered as endemic. Shifting population must surely give cause for concern; people from the mountainous areas, many due to economic stress, tend to travel to urban and industrial areas in search of work.

Ignorance and prejudice are the worst obstacles to the Centre's and the Board's work. The Centre's explicit pamphlet on the recognition, treatment and cure, and social problems of the disease helps, but centuries of ignorance have left deeply ingrained inhibitions. The disease is curable, and one of the world's least infectious; seventy per cent of the world's sufferers are claimed to be in the non-infectious group, and, as the Centre records, 80 per cent of the world's population is naturally immune.

In a national effort to dispel prejudice and ignorance, the Centre has undertaken a schools education-cum-fund-raising campaign. Its success in Karachi has been beyond expectations. Hundreds of thousands of rupees have been collected for the control programme, and education courses have been held. The programme will be spread over other parts of Pakistan.

The year 2000 has become significant for other local and world campaigns—one can but repeat, fortunately—Pakistan is a low incidence area.—*A.F.*

Leprosy in India

MRS. GHANDHI has emphasised that two issues in India should receive

special emphasis in the present year—leprosy and blindness. A leprosy seal campaign is going on at present in India and she said her Government was in constant touch with the WHO and other institutions to eradicate leprosy. Because of the non-acceptance even of cured patients in society the Prime Minister said, there were instances of the disease being hidden by sufferers in the early stages. Mrs Ghandhi said that leprosy was on the increase in Asia and Africa, and therefore early check of all employees and students was essential

CSO: 5400/5980

NEW STRAINS OF MALARIA REPORTED

Lahore VIEWPOINT in English 6 May 82 p 32

[Text] **Malaria – Deadly new forms and deadly increase?**

FROM Nairobi comes a reliable report that in at least 100 countries of the Third World malaria is creeping back in seemingly new and more deadly forms, and in Africa, tragically, the victims are mainly amongst children and pregnant mothers The new strains appear to be resistant to the so far accepted anti-malarial drugs.

In the 1960s the WHO had hoped to eradicate malaria completely – the compaign was moderately successful. However, in the seventies it was observed that the number of victims began to rise steeply, not only in Africa but in other countries of the Third World. Onwards into the seventies the number of cases actually doubled, and in the late seventies there were 800 million infections and over one million deaths

The WHO and FAO have refuted the view of certain scientists that massive use of chemicals, including DDT on crops has produced drug-resistant strains in malarial parasites.

The newer strains are far deadlier than the old, hitherto unknown. Malarial parasites known in the past lay dormant in the liver, bringing about recurring attacks of the fever. However the new strains invade the red blood cells causing total congestion in internal organs, bringing about rapid death – sometimes within 24 hours. One million African children are believed to have died, succumbing to these new, deadly strains. Work on the search for new immunity is unfortunately still in the experimental stage.

CSO: 5400/5980

CEREBRAL MALARIA CASES, DEATHS REPORTED

Johannesburg THE CITIZEN in English 20 May 82 p 9

[Text] ALTHOUGH two Whites had died from cerebral malaria a fortnight after they visited the malaria belt in the Eastern Transvaal, a third patient, who also contracted cerebral malaria, could be discharged from hospital this weekend.

He has received intensive treatment at the Johannesburg Hospital since the 5th of this month and it has proved entirely successful.

A hospital spokesman said the names of the patients would not be made public. They were being withheld at the request of their families.

No further cases of cerebral malaria in the Kruger National Park have been reported to the Department of Health in Pretoria nor does it expect them to be, a spokesman for the department told The Citizen.

"Such cases are not usually reported to us," he explained yesterday.

"When the latest cases were brought to our attention we took the opportunity of warning visitors not to assume that they were safe from mosquitoes in the winter months or that anti-malaria precautions could be neglected.

"It cannot be taken for granted," he said.

There were no statistics for what proportion of cerebral malaria cases proved fatal but it should be viewed as a killer disease, the spokesman added.

"All visitors to a malaria area like the Kruger Park are equally susceptible and should take strict precautions before, during and after their stay."

Living quarters should be made mosquito-proof. Doors should be screened and the room sprayed with an effective insecticide.

Visitors should sleep under mosquito nets large enough to cover the whole bed and rub a mosquito repellent into their face and hands before going to bed.

If they go out of doors after sunset they should make a point of wearing long trousers, long-sleeved shirts and ankle boots.

During the malaria season, which included the winter months, visitors should take prophylactic drugs in the form of tablets for adults and syrup for children, the Department of Health spokesman said.

These could be obtained without a prescription.

They should be taken first before entering the malaria area, then throughout the course of the stay and finally for four to six weeks after leaving.

"And if the worst happens and a visitor to the park thinks he has developed any of the malaria symptoms, he should lose no time in going to a doctor, having the sickness identified and taking a blood test," the spokesman said.

CSO: 5400/5989

SHARP RISE IN CHOLERA CASES

Johannesburg THE CITIZEN in English 20 May 82 p 10

[Text] THERE was a dramatic rise in the number of cholera cases admitted to hospitals serving Blacks in the Johannesburg region during the first four months of this year.

The MEC in charge of hospital services, Dr Servaas Latsky, told the Transvaal Provincial Council yesterday that between January and April this year, nine people suffering from cholera had been admitted to the Hillbrow Hospital and eight to Baragwanath.

Replying to a question from Mr Sam Moss (PFP, Parktown), Dr Latsky said that during the whole of 1981 only three cholera patients had been admitted to Baragwanath and only one to Hillbrow.

A total of seven Transvaal Provincial hospitals which had not treated any cholera patients last year admitted their first such patients this year, while four hospitals which had previously treated cholera patients did not admit any during the first four months of the year.

But during the same period a total of 238 beds were commissioned or recommissioned in the Transvaal.

These were at the Andrew McColm (18 beds); Hillbrow (74 beds); Kalafong (90 beds); Natalspruit (12); Standerton (five beds) Sybrand van Niekerk (five beds) and Vereeniging (32 beds) Hospitals.

CSO: 5400/5989

BRIEFS

ANTI-CHOLERA MEASURES--Seoul, 12 May (YONHAP)--The Korean Health-Social Affairs Ministry Wednesday instructed quarantine stations and public health centers across the country to strengthen preventive measures against cholera. A ministry official said such moves are necessary in light of the fact that Japan and Hong Kong have experienced recent cases of cholera. According to the official, all travelers arriving in Korea from Thailand or Malaysia, where cholera can occur, must undergo a feces examination before clearing immigration. The ministry will also strengthen anti-cholera measures in domestic areas where outbreaks have been recorded in the past. [Text] [SK120238 Seoul YONHAP in English 0222 GMT 12 May 82]

CSO: 4120/267

WHOOPING COUGH EPIDEMIC CONCERNS PHYSICIANS

Stockholm DAGENS NYHETER in Swedish 3 Apr 82 p 10

[Article by David Finer]

[Text] "We are going to apply for permission to test a British whooping cough vaccine on between 1,000 and 2,000 infants in Stockholm. If our request is approved, we can have the results ready by the end of summer. If the vaccine is satisfactory, the Social Welfare Board can decide to import it and let Swedish physicians give it, under license, to newborn infants who are at risk."

So says Associate Prof Patrick Olin, chief physician at the Sachs Childrens Hospital in Stockholm. A meeting of all chief physicians concerned with children's health in Stockholm County was held yesterday. There was deep concern over the fact that Swedish children are not protected against whooping cough at a time when information from Great Britain indicates a definite rise in the number of cases this year.

As DAGENS NYHETER reported yesterday, Per Askelof, microbiologist at the SBL (National Bacteriological Laboratory), warned of the whooping cough situation at a Scandinavian meeting on vaccination that was held in Stockholm last Saturday.

He pointed out that Sweden is the only country that lacks an official recommendation on vaccination against whooping cough. At the same time, an epidemic that may claim the lives of several infants is anticipated this winter.

Per Askelof says: "I myself have small children, and I am really afraid of what may happen."

The background to the current situation is complicated. During the 1970's, the SBL manufactured a weak vaccine which barely provided even 50-percent protection but which produced milder forms of the disease.

Since the vaccine was so weak and the risk of side effects small but not negligible (permanent brain damage in 1 case out of about 300,000), the vaccine was withdrawn in the summer of 1979.

Per Askelof says: "Then we tried to import a British vaccine, but the Social Welfare Board considered it insufficiently documented and rejected our request in September 1979. After all, enough vaccine would have been supplied to meet Sweden's requirements for from 40 to 50 years, and there was no vaccine that had been better tested."

What worries Askelof is the experience in Japan and Great Britain, where vaccinations were also halted in the 1970's with disastrous results.

Children Died

"In Japan in 1974, 80 percent of the children were protected by whooping cough vaccine. There were 400 reported cases and no deaths. In 1976, the vaccination coverage had dropped to 15 percent. In 1979, there were over 13,000 cases, and 41 children died. Over 90 percent of the deaths occurred among unvaccinated children, and almost all the deaths involved children under 1 year of age.

"In Great Britain the vaccination coverage had dropped to 40 percent in 1976. In the epidemic of 1977-1978, there were more than 50,000 cases and 12 deaths."

When Sweden decided in 1979 to discontinue vaccinations, it was still not known what had happened in Japan and Great Britain. And now it is a bit late, says Askelof. He feels that we can expect a new epidemic this fall.

He says: "Whooping cough peaks every third or fourth year. We hit a peak in 1970 with 2,300 reported cases, followed by 2,700 in 1974 and a good 8,600 in 1978. We can therefore expect another peak in 1982.

"It is true that there is a clause on epidemics which states that vaccines can be imported in emergency situations during severe epidemics. But that may be too late. It takes 3 or 4 months to import the vaccine and vaccinate all children in the danger zone. I want to see to it that we have the vaccine and, preferably, begin vaccinating at least all children under 1 year of age as soon as possible. The protection does not last for more than 2 or 3 years, so no Swedish child is protected today."

Dr Margit Nordlander of the Social Welfare Board's Pharmaceutical Department in Uppsala feels that Askelof is exaggerating.

In no Hurry

"That is scare propaganda. We are in no hurry. If an epidemic occurs, we can think about importing the British vaccine. Besides, the cases of whooping cough that occurred over the past year were mild and could be handled with antibiotics.

"The Social Welfare Board is currently calling for documentation on various vaccines, and we will then decide whether to import or not. It should not be forgotten that the vaccine also has side effects. It is true that they are rare, but they are tragic for those concerned.

"We have never denied vaccine licenses for groups of Swedish children at risk--those with chronic illnesses, for example. And the British vaccine has been tested clinically here in Sweden."

Dr Patrick Olin, children's chief physician at the Sachs Childrens Hospital in Stockholm, confirms that the British vaccine has been tested, but the results have never been published. Only about 60 children took part, and none of them were actually infants.

Couple of Years Required

"That is why we want to test the same vaccine above all with younger children. The reason is that newborn infants can be regarded as 'children at risk' in precisely the same way as children with chronic illnesses.

"If the Social Welfare Board's Pharmaceutical Committee, the ethics committees, and other entities concerned say yes, perhaps we can have preliminary results by the end of summer. Then the Social Welfare Board can permit a general vaccination with the vaccine under license."

Associate Professor Olin says: "Another couple of years will probably be required before a new vaccine can be approved as a registered drug."

According to Per Askelof, it would take just as long for the SBL to produce a vaccine of its own. Work is currently underway to "copy" a Japanese whooping cough vaccine with few side effects.

"But the production department does not have the resources for producing a vaccine on a large scale. Our work will make up for the SBL's shortfall, but there will be no money left over for reinvestment in production activity. We will eventually be an independent vaccine institute, but we are not one today."

DAGENS NYHETER also reported yesterday that the use of gamma globulin has declined, with cases of jaundice and malaria rising as a result. One reason may be a statement by Prof Sten Iwarsson, a specialist in infectious diseases at the Eastern Hospital in Goteborg, who at last year's national medical convention urged travelers within Europe not to bother about the gamma globulin shot. Professor Iwarsson refused on Friday to comment to DAGENS NYHETER concerning that statement.

11798
CSO: 5400/2130

BRIEFS

DYSENTERY INCIDENCE, DEATHS--Dysentery which broke out in the city of Dar es Salaam has already killed two people but steps to combat the disease have already been taken, the chief physician of Dar es Salaam Region, Dr Mtey, said yesterday in the city of Dar es Salaam. He said that this disease, which broke out in various parts of the city of Dar es Salaam and compelled the hospital in Muhimbili to set aside special wards for serving dysentery patients, results from uncleanliness in the environment exacerbated by dirty water and flies. He added that it is estimated that 250-300 people have already been the victims of this disease, which is similar to that which broke out recently on the Island of Zanzibar. He stated that the number of people who have become ill from this disease, which started in Temeke District and later spread to the School of Accounting and Ukonga and Kinondoni prisons, has been reduced as a result of various steps taken to confront it. [Text] [Dar es Salaam UHURU in Swahili 13 May 82 p 1]

DYSENTERY REPORTS--Micheweni District: Reports from Pemba say that a serious outbreak of dysentery has occurred for the first time in various areas of Micheweni District. According to a statement issued by the director of health and social welfare in Pemba, Ndugu Said Hamoud, 18 persons have so far been affected, 12 of them hospitalized. Reports say that one of those hospitalized died and five others were released. [Excerpt] [EA300212 Zanzibar Domestic Service in Swahili 1600 GMT 29 May 82]

CSO: 5400/5601

BRIEFS

SCHISTOSOMIASIS ERADICATION PROJECT--ITT Zambia, in conjunction with the Ministry of Health will soon launch a K40,000 research project aimed at eradicating snails which spread bilharzia. The money is part of K1 billion spent annually by ITT on research development programmes. The spokesman said the research would be carried out by a team of specialists from London headed by Mr Cyril Drake, chief research fellow with Standard Telecommunication Laboratories Limited and an official from the Ministry of Health. [Excerpt] [Lusaka TIMES OF ZAMBIA in English 7 May 82 p 7]

CSO: 5400/5985

BRIEFS

CATTLE DISEASE EPIDEMIC--Brahmanbaria, Apr 30--Hundreds of cattle died during past one month in different villages of Brahmanbaria police station following attack by an unknown disease. Reports said the first symptom was that the attacked animal becomes dumb and, in most of the cases, die within three or four hours. Farmers are passing frightful days since no preventive measure against the strange disease is still available. [Text] [Dacca THE NEW NATION in English 4 May 82 p 2]

CSO: 5400/7071

DANES SUSPECT GDR IS ORIGIN OF FOOT-AND-MOUTH DISEASE

Stockholm 7 DAGAR in Swedish 2 Apr 82 p 25

[Article by Mats Gezelius]

[Text] The first sick animal was discovered on Thursday 18 March on a farm in the little village of Brenderup on the Danish farming island of Fyn. A veterinarian was called in, and he quickly noted the typical symptoms:

Heavy salivation giving rise to smacking sounds, fever and some degree of lameness, and inflammation of the tongue, the inside of the lips, and the muzzle, as well as of the areas around the teats and hooves.

His diagnosis confirmed the farmer's fears: it was Aphthae epizooticae, or hoof-and-mouth disease.

All the animals on the farm were destroyed and buried immediately. Since then, thousands of calves, cows, and pigs--entire herds--have been destroyed and buried on the spot using bulldozers.

Entire villages have been isolated, and the children have been kept home from school.

Mail and food have been left at a safe distance from the farms, and no visiting has been allowed--not even by medical personnel.

Such tragic scenes remind one of the time of the Black Death.

Why are thousands upon thousands of prime slaughter animals being killed for having hoof-and-mouth disease--a disease that in any case runs its course in a couple of weeks?

Why doesn't Denmark--a country whose economy depends on agriculture--use the vaccines against hoof-and-mouth disease that exist and are used in most of Europe?

From GDR

Where did the infection come from, and how could it hit Denmark despite strict restrictions?

Goran Hugosson, who is an expert on hoof-and-mouth disease and teaches at the Institute of Veterinary Medicine in Uppsala, says: "Everything indicates that the disease is coming primarily from the GDR. It was probably spread through the air--the strictest restrictions are ignored by the wind.

"We now know for sure that the various viruses that cause the disease can be carried long distances in the air. Especially when it is cold, damp, and cloudy. So that is another reason for us to be thankful that spring has arrived."

But the glare of the springtime sun does not mean that Swedish farms are not in danger of being hit by the Danish disease. Hoof-and-mouth disease is extremely contagious. It is easily spread from one animal to another through milk or meat from infected animals, by humans, dogs, rats, poultry, migratory birds, objects from infected localities, automobiles, and so on.

Since no animals in either Sweden or Denmark are immunized against hoof-and-mouth disease, an epizootic (epidemic of hoof-and-mouth disease) would rapidly affect all animals. It is against that background that one must view the drastic measures introduced very quickly when the first case was discovered on Denmark's Fyn Island.

Most Survive

If the disease is allowed to develop, vesicles soon appear on the inflamed parts. They then burst and leave superficial sores. The animals lose their appetite and quickly lose weight. Their milk will also dry up at the same time.

But in general, all animals survive the acute phase, which lasts only a couple of weeks. The death rate among adult animals is no higher than 1 animal out of every 200.

But the animals would never become completely healthy again. Forever after, their growth would be stunted, reproduction would decline, and their susceptibility to various aftereffects would be high. That is what makes the disease so tremendously expensive to agriculture.

Hoof-and-mouth disease strikes all ruminants, but particularly cattle and swine. In large parts of Asia and Africa, it is widespread and stationary, but it has relatively little effect on the animals there compared to what it does to our highly bred and highly productive animals, which have long been protected from the infection.

In a country whose agriculture is highly technological and highly productive, the economic consequences of an epidemic of hoof-and-mouth disease would be

enormous. So when the first infected animal was found on Fyn, the immediate reaction was to destroy and bury all of the farm's 39 animals. Since then, several thousand more cattle and swine have been destroyed.

Total Slaughter

As a rule, there are three ways to attack hoof-and-mouth disease when it does appear, says Goran Hugosson. There can be a total slaughter of all livestock. Or the infected stock can be slaughtered in combination with large-scale vaccination. Or the infected farms, villages, or regions can be placed in total isolation while the disease runs its course.

Denmark has chosen the first course of action to stop the infection quickly.

"That is the natural reaction to an infection. One must strike hard in the very beginning to stop the infection. But if that strategy does not have the desired effect very quickly, one must change strategies and either vaccinate or isolate. Because, of course, one cannot slaughter all the livestock."

That attitude is shared by the farmers on Fyn, who are demanding that all the animals on the island be immunized. But the Danish Ministry of Agriculture is unresponsive. Why?

For the individual farmer, a hoof-and-mouth infection is the worst thing that can happen. For Danish society as a whole, it may be better to slaughter a rather large percentage of the livestock than to immunize all the animals.

The reason is that even if it is immune to hoof-and-mouth disease, an immunized animal can continue to be a carrier of the disease for 2 or 3 years. If Denmark immunized its cows and pigs against hoof-and-mouth disease, the country would be regarded as permanently subject to that disease.

The reaction from many of the countries most important to Denmark's export trade would be to place a total ban on imports of fresh Danish meat for a number of years to come.

Another problem with immunization is that while it certainly protects against the specific viruses for which the vaccine is intended, the animals are still not totally immune to hoof-and-mouth disease.

The disease is caused by a great number of viruses. They are usually divided into seven main groups, of which three occur in Europe: "O", "A," and "C." The "O" type is the most common, and it is a virus of the "01" type that has now hit Denmark.

Sweden's preparedness program for hoof-and-mouth disease is contained in a statute over 50 pages long. It specifies how the authorities, the police, Customs, the National Board of Agriculture, veterinarians, and so on are to proceed.

Since Sweden is not as dependent on agricultural exports as Denmark is, it has somewhat more freedom to choose its weapons for the fight if the infection should spread to this country. If the attempts to stop the infection at the Sound fail, the first countermeasures would be the same as those in Denmark--destruction and burial of the animals in special graves on the site and strict regulations concerning isolation and sanitation.

11798
CSO: 5400/2130

FOOT-AND-MOUTH DISEASE SPREADING ON FYN

Stockholm DAGENS NYHETER in Swedish 7 Apr 82 p 12

[Article by Thomas Jonsson]

[Text] Copenhagen, Tuesday--Hoof-and-mouth disease struck again on Fyn Island on Tuesday, and 158 animals have been killed on two farms. Danish authorities are now urging all Fyn residents to stay home over the Easter weekend.

People traveling to Denmark are being urged not to stop on Fyn.

The two new cases on Tuesday were the 13th and 14th since hoof-and-mouth disease first struck Denmark on 18 March.

A total of 3,482 cattle and swine on the farms hit by the disease have now been slaughtered because of the emergency.

The new cases occurred in Ferritslev and Ullerslev in the southeastern part of Fyn. Hoof-and-mouth disease has so far stayed within a 15-kilometer radius.

The danger that the infection will spread increases markedly as each new farm is hit by the disease.

Erik Stougaard, head of the National Veterinary Directorate, said on Tuesday: "This has been absolutely more than we counted on.

"But the cases of the disease are so concentrated on Fyn that we still feel that we have the situation under control."

Quarantine

But the authorities are now putting all of Fyn under something like a quarantine. People are being urged to stay home over the Easter weekend. It is doubtful whether athletic clubs on the island will send teams to the traditional Easter competitions that are held all around the country.

Organizers of various kinds all over Denmark are being advised not to organize gatherings of people.

Tuesday's new cases of the disease have given new impetus to demands that the livestock on Fyn be immunized. But Minister of Agriculture Bjorn Westh reiterated on Tuesday his earlier refusal to immunize--injections will be started only if the EC countries halt their imports of Danish meat.

It is expected that immunization against hoof-and-mouth disease will harm Danish meat exports for many years to come. Immunized animals are regarded as carriers by countries--among them Sweden--which completely eliminated hoof-and-mouth disease long ago.

But there are signs that the EC may also begin to hesitate to buy Danish meat.

Import Ban

On Tuesday, West German Minister of Agriculture Josef Ertl received a strong demand for an import ban from farmers in the border state of Schleswig-Holstein. They are afraid that hoof-and-mouth disease will enter through the border stations along the frontier with Denmark.

11798
CSO: 5400/2130

AUTHORITIES REFUSE TO VACCINATE FOR FOOT-AND-MOUTH DISEASE

Stockholm DAGENS NYHETER in Swedish 8 Apr 82 p 5

[Article by Thomas Jonsson]

[Text] Copenhagen, Wednesday--The 15th case of hoof-and-mouth disease was discovered on Fyn Island on Wednesday morning. But the Danish Ministry of Agriculture still does not want to start vaccinating, since that would harm Danish meat exports for a long time to come.

The new case of the disease--the third in 24 hours--occurred on a farm in Gudme in the vicinity of the farms where all the previous cases of hoof-and-mouth disease have been found. It was necessary to slaughter 209 pigs and cows on Wednesday.

Veterinary officials are pessimistic.

Erik Stougaard, head of the National Veterinary Directorate, noted on Wednesday: "Now we are expecting damp weather for Easter, and that may increase the danger of the spread of the infection between farms."

Following an emergency meeting on Wednesday afternoon with the authorities concerned, Minister of Agriculture Bjorn Westh announced that there are still no plans to vaccinate livestock on Fyn Island.

"The situation is not explosive," said Westh. "The infection has not spread beyond Fyn."

The government is now thinking of compensating the affected farmers for their operating losses due to the disease as well as for the value of the animals slaughtered in this emergency.

So far, 3,691 animals valued at a good 11 million Danish kroner have been slaughtered as a result of the attack of hoof-and-mouth disease.

11798
CSO: 5400/2130

FOOT-AND-MOUTH DISEASE NOW CONFIRMED ON SJAELLAND

Copenhagen BERLINGSKE TIDENDE in Danish 5 May 82 p 1

[Article by Anders Wiig]

[Text] Last night a confirmed case of hoof-and-mouth disease was found on Sjaelland. Just as veterinary authorities were hoping the feared cattle disease had been halted with the last outbreak on Fyn, since the incubation period had expired, the disease cropped up in a herd near Skaelskor.

At 1700 hours, the State Veterinary Institute for Virus Research on Lindholm Island received samples from the herd of farmer Jens Sorensen of Vinagergard in Vedskolle, east of Skaelskor. The samples were sent by district veterinarian Erhardt Frederiksen of Ringsted. It took the institute only 2 hours to analyze the samples and confirm the suspicion that hoof-and-mouth disease now exists on Sjaelland too.

At 1900 hours, the district veterinarian reported the outbreak to the police station in Slagelse. There, police superintendent Erik Jensen immediately blocked off Vinagergard which is located on Vinagergardsvej in Vedskolle, 6 kilometers east of Skaelskor.

The arrow shows the location of the confirmed outbreak on Sjaelland.

Access to the farm and the immediate vicinity was restricted by means of signs. At the same time the municipality was informed and asked to provide a suitable spot for burial of the 60 hoofed animals which were slaughtered on the farm last night. This was done by a local butcher in cooperation with Falck's Rescue Corps which provided a force of 10 men in protective clothing and set up emergency lights on the farm. No information was available last night concerning how the suspicions arose. The new outbreak is probably due to infection from recent hoof-and-mouth cases in East Germany. Minister of Agriculture Bjorn Westh said last night that vaccination is not being started.

On Tuesday evening he asked butchers on Sjaelland and Lolland-Falster to stop accepting animals for slaughter starting Wednesday.

6578
CSO: 5400/2148

AUTHORITIES THINK SJAELLAND FOOT-AND-MOUTH DISEASE FROM GDR

Copenhagen BERLINGSKE TIDENDE in Danish 6 May 82 p 3

[Article by Jens Trudso]

[Text] Veterinary authorities think it probable that the latest outbreak of hoof-and-mouth disease was brought to Sjaelland on winds blowing from East Germany.

District veterinarian Erhardt Frederiksen of Ringsted, who discovered that a heifer in a herd at Vinagergard in Vedskolle, east of Skaelskor, was suffering from the disease, said last night to BERLINGSKE TIDENDE that no information had come to light on Wednesday that indicated any other possibility for the spread of the disease.

The outbreak of hoof-and-mouth disease was discovered so early that it is possible this herd produced only a limited amount of the virus.

But veterinary director Erik Stougaard said yesterday that the humidity in the air and the weather we now have make it possible for hoof-and-mouth disease to survive for long periods.

Yesterday, slaughterhouses on Sjaelland halted all slaughtering operations until Monday. Slaughterhouses in Nykobing Falster, Vordingborg, Ringsted, Holbaek, Slagelse, Frederikssund and Copenhagen normally slaughter around 50,000 pigs a week, but the ban on slaughtering will not cause any great meat supply problems on Sjaelland for the moment, according to the slaughterhouse association, ESS-Food.

The observation area around Vedskolle is primarily a crop-production area. There is almost no cattle raising and several farms have no animals at all, according to pig-breeding consultant Kjeld Petersen of the Skaelskor District Farm Association.

Swedish veterinary authorities are concerned that hoof-and-mouth disease has come closer to them with the outbreak on Sjaelland.

Many Swedes came to the Danish-Swedish national soccer match in Idraets Park in Copenhagen last night and like other Swedes visiting Denmark, they were instructed to keep away from cattle and farm properties.

After consultations with the district veterinarian in Nykobing Falster, the Naestved Kayak and Canoe Club decided to call off the Susa race on Saturday, 5 May due to the spread of hoof-and-mouth disease to Sjaelland.

Instead they are planning to hold the Susa race on 11 September.

The Danish Horsemen's Society has decided to call off all national and regional contests for horses and ponies temporarily, for the period ending 24 May.

District competitions can still be held for horses and carriages coming from the district in question. Horses and carriages from the isolation area will not be allowed to compete in riding competitions outside the area.

6578
CSO: 5400/2148

BRIEFS

FOOT-AND-MOUTH QUARANTINE--The GDR Ministry for Agriculture, Forestry and Foodstuffs announced in a status report on foot-and-mouth disease that effective 7 May the quarantine in Ribnitz-Damgarten Kreis and in Stralsund Kreis will be generally lifted. Beginning on that date entry into and exit from these regions will again be allowed. The Darss/Zingst Peninsula and some villages in Ribnitz-Damgarten, Stralsund and Grimmen Kreise previously affected by hoof and mouth disease will remain under quarantine. Highway number 105 is blocked in the village of Karnin, Stralsund Kreis, and traffic is being rerouted. [Text] [DW061109 East Berlin Domestic Television Service in German 1730 GMT 5 May 82]

CSO: 5400/2152

LONGER ZINC DOSING PERIOD EFFECTIVE AGAINST FACIAL ECZEMA

Auckland THE NEW ZEALAND HERALD in English 16 Apr 82 p 10

[Text] **Ruakura scientists have confirmed that zinc dosing can remain effective as a protection against facial eczema for up to seven weeks.**

This important news may give farmers the chance to start dosing their stock when facial eczema spore levels is pasture start to rise — but before they reach danger levels.

They could then continue to dose with zinc for up to seven weeks, a period which in most seasons should cover the period when facial eczema is a threat.

The treatment would need to be continued right through the period when spore numbers are at danger levels.

Recent trial work at the Ruakura Animal Research Station indicates that the best results come from daily dosing.

A seven-day dose has also been shown to be effective in reducing facial eczema effects in sheep and lactating dairy cows.

Some Problems

However, Dr Neale Towers, a scientist engaged in the research, warns that weekly dosing is not without problems, particularly for dairy cows in milk.

Further trials are being set down to confirm the recent Ruakura results and to obtain extra information about dose rates and the period of dosing, which gives the greatest protection.

Until recently Ministry of Agriculture and Fisheries scientists have been cautious about recommending the continuous use of zinc salts for longer than three or four weeks.

Dr Towers says this caution had been due to a lack of information on how long zinc dosing would remain effective and concern about zinc toxicity.

"Animals are known to adjust to excessive intakes of minerals and there is some evidence that this may occur after three or four weeks," he says.

Other Groups

However, Dr Towers now has results from a Ruakura trial in which sheep were dosed daily with zinc oxide for seven weeks before being exposed to the facial eczema toxin, sporidesmin.

Other groups have been dosed daily for four weeks or one week before dosing with sporidesmin.

In addition, a further group was dosed once a week for seven weeks, each dose containing a seven-day zinc oxide supply.

Dr Towers says results from the trial showed that all zinc treatments gave some protection against facial eczema.

Best results were found in the groups dosed with zinc for seven or four weeks before being challenged with sporidesmin.

These groups received much greater protection than the group dosed with zinc for the week during which they were also dosed with sporidesmin.

Dr Towers says the increased protection found in such groups may lead to a reassessment of the recommended methods of using zinc salts to protect against facial eczema.

Practical View

From a practical farming point of view the idea of giving animals a seven-day dose once a week is likely to arouse most interest among farmers.

But although a seven-week dosing by this method offers protection, it is not without problems.

Dr Towers says the most significant of these is a drop in milk yields in lactating dairy cows.

"In the Ruakura trials, milk yields dropped 10 per cent to 15 per cent over the 48 hours following dosing at once weekly dose rates," he says.

"Milk rates did not return to normal within a further 48 hours."

Dr Towers says that this season Ruakura has received reports of other problems following once a week dosing.

Large Herds

In a few instances one or two cows from large herds have required veterinary treatment 24 hours after weekly zinc oxide dosing.

The problems have not showed in the Ruakura trials, these having been conducted with relatively few animals.

Dr Towers says it is not certain that the problems reported were due to zinc dosing, but farmers should be cautious about adopting once-weekly zinc oxide dosing as a protection procedure for milking cattle.

CSO: 5400/9084

BRIEFS

SHEEP PNEUMONIA VACCINE--Wellington (PA)--Scientists have made a breakthrough in the prevention of a pneumonia strain affecting lambs which costs the sheep industry up to $12 million a year. Ministry of Agriculture and Fisheries researchers said they had developed a vaccine which heavily reduced the incidence of enzootic pneumonia--the first successful vaccine in this field developed anywhere in the world. The disease, which affects lambs mainly in February and March, costs the industry between $7 and $12 million a year in lost production. On some farms up to 60 per cent of lambs are affected, and deaths can be as high as 15 per cent. The ministry's new vaccine reduced incidence of the disease by 50 per cent in trials in Northland this year according to Dr Hugh Davies, a scientist at the Wallaceville Animal Research Centre. "Its is the first successful vaccine in the area of sheep pneumonia anywhere in the world, so from that point of view it is a breakthrough," said Dr Davies. It would be some years before the vaccine would be available commercially, he said. [Text] [Christchurch THE PRESS in English 8 Apr 82 p 30]

CSO: 5400/9085

GOVERNMENTS URGED TO ERADICATE LIVESTOCK DISEASES

Kaduna NEW NIGERIAN in English 30 Apr 82 p 9

[Article by Aliyu Modibbo]

[Text]

BETTER standards of animal health and husbandry amongst cattle as well as other species of livestock can not be obtained unless concerted efforts are made by all governments to eradicate rinderpest and other contagious cattle diseases.

The Kaduna State Commissioner for Animal and Forest Resources, Alhaji Lawal Sani Zangon Daura made this remark yesterday while opening the Annual National Co-ordination Committee meeting of the Federal Livestock Department, Epidemiology units at Durbar Hotel, Kaduna.

Alhaji Lawal Sani Zangon Daura said the hazards of livestock diseases have been causing heavy economic loss to the livestock owners as well as incurred greater loss of quality food to the nation especially in the requirement of animal protein.

He said the campaign on the dangers of the livestock diseases must be carried out in the rural areas, adding that the successes depended largely on the provision of personnel, scientific equipment and supervision.

Alhaji Lawal stated that Kaduna State being one of the livestock producing areas in the country was contributing its quota in the development of livestock health and production.

He announced that during the second and third national development plans, the state government had built seven new veterinary centres, three veterinary hospitals, 30 new veterinary clinics and 19 cattle dips.

He announced that the government paid about 62,733 Naira as compensation to the herds' owners who were affected by the government "compulsory herd slaughter policy" to control nine outbreaks of rinderpest in 1980.

In his speech, the Director of Federal Livestock Department, Dr. K.B. David West said cattle played a significant role in the economy of the country and control of cattle and other livestock diseases demanded high priority at all levels of governments' programmes.

He said that governments were experiencing an increase in the incident of cattle diseases in the country. He said the phenomena required more concerted efforts on the parts of all governments to control the situation.

CSO: 5400/5992

BRIEFS

FOOT-AND-MOUTH DISEASE ALERT--Malmo, Tuesday--Swedish authorities are now intensifying precautions against hoof-and-mouth disease, and veterinarians in Malmohus County are starting a 24-hour service. This is partly because of the continuing spread of the epizootics in Denmark and the GDR and partly because of the upcoming Easter weekend, when a large increase in the flow of travelers to and from both the affected countries is expected. Every traveler passing through the present customs stations now receives a brochure prepared by the National Board of Agriculture and containing information, advice, and instructions. In addition, the district veterinarians in Malmohus County, which is naturally the prime danger zone, have stepped up their preparedness by starting a so-called backup service, according to what DAGENS NYHETER was told by County Veterinarian Sven Otterlin, who himself has also started a 24-hour service. He has also advised dairies, slaughterhouses, and feed companies to tighten up their hygienic measures, and none of them is to visit stables unnecessarily. If the infection reaches Sweden despite the precautions, the authorities are prepared to strike lightning fast. An isolation zone with a radius of from 2 to 5 kilometers will be set up around the affected livestock. And in addition to the purely veterinary measures, dairies will be ordered to raise their milk pasteurization temperature from the normal 72° to 80° to be absolutely sure of preventing the infection from being spread in that way. [Text] [Stockholm DAGENS NYHETER in Swedish 7 Apr 82 p 12] 11798

CSO: 5400/2130

BRIEFS

FOOT-AND-MOUTH DISEASE--Minister of State for Agriculture and Water Development Mr Noah Delamono has said his ministry has successfully controlled the spread of foot and mouth disease in the southern province. Mr Delamuno said the disease had been subdued and only a blanket cover, the third and final vaccination of animals was remaining. [Excerpt] [CA010152 Lusaka Domestic Service in English 0500 GMT 31 May 82]

CSO: 5400/5602

GOVERNMENT CRITICIZED FOR INACTION IN FIGHTING LOCUST PLAGUE

Perth THE WEST AUSTRALIAN in English 14 Apr 82 p 26

[Text] Locusts are in plague proportions at Gnowangerup, but the Agricultural Protection Board is refusing to take action against them.

The chairman of the APB, Mr Neil Hogstrom, said yesterday that the board would act only if crops were at risk.

"We recognise that there is a plague of locusts in the district but the insects are eating only unseasonal summer pasture," he said.

"The pasture and the grasshoppers were brought on by the heavy January rains creating an unseasonal problem.

"If the problem still exists in spring when crops will be in danger the board will initiate controlled chemical spraying.

"It costs the board--and therefore the taxpayer--$8 a hectare to spray paddocks.

"For green pasture which does not normally grow at this time of the year that kind of expense is not justified."

But the MLA for Roe, Mr Geoff Grewar, said yesterday that farmers feared for their spring crops unless immediate action was taken.

"They are concerned that, if the locusts are allowed to go on breeding, plague proportions reached in spring could be horrendous," he said.

Mr Grewar said that the APB should spray at least the isolated locust breeding spots.

This should significantly reduce numbers without putting the Government to great expense.

The Gnowangerup Shire Council said yesterday that the APB had refused to recognise the locust problem.

The shire clerk, Mr Peter Bennett, said that the problem had existed for about five weeks and much green stock feed had seriously been damaged.

CSO: 5400/7551

BRIEFS

THAI BINH DROUGHT, PEST INFESTATION--To date 5th month-spring rice on 58,000 hectares in Thai Binh Province has blossomed. This rice, however, has been affected by drought on 17,000 hectares and by insects and blight on 19,000 hectares. The province has decided to use three-fourths of its electric output to combat drought and mobilize all sources of insecticide to eliminate insects in an effort to protect this rice. [BK190939 Hanoi Domestic Service in Vietnamese 1430 GMT 15 May 82 BK]

CSO: 5400/5994

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